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INCLUDING SYPHILIS

Under the Editorial Direction of

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THE JOURNAL OF CUTANEOUS DISEASES

INCLUDING SYPHILIS

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CONTENTS.

ORIGINAL COMMUNICATIONS.

Osteopathies of Quaternary Syphilis. Professor GAUCHER and Dr. LEVY-BING.....	1
Erythema Exudativum Multiforme with Report of a Case of Erythema Circinatum Bullosum et Hæmorrhagicum Following Gunshot Wound, Apparently Due to Streptococcus Infection and Terminating Fatally. WILLIAM THOMAS CORLETT, M. D....	7
Note on a Case of Sarcoid. S. POLLITZER, M. D.....	15
Multiple Benign Cystic Epithelioma. M. L. HEIDINGSFELD, M. D.	18
Easy and Rapid Method of Micro-chemical Research for Mercury in the Urine. Dr. C. LOMBARDO	29

SOCIETY TRANSACTIONS.

CHICAGO DERMATOLOGICAL SOCIETY (October)	31
Two Cases of Leprosy—Tuberculosis of the Skin—Acne Necrotisans Serpiginosa Nasi—Pityriasis Rosea—Cutaneous Blastomycosis—Lupus Erythematosus—Multiple Sebaceous Cysts of the Scrotum—Leukoplakia of the Vulva with Carcinomatous change.	
BOSTON DERMATOLOGICAL SOCIETY (April)	34
Adenoma Sebaceum—Lupus Erythematosus (?)—Extragenital Chancere—Derma- titis Calorica or Hydroa-æstivale—Pityriasis Rosea of Atypical Distribution.	
NEW YORK ACADEMY OF MEDICINE, SECTION OF DERMATOLOGY (October)	36
Case for Diagnosis—Elephantiasis—Sclerosis of Nipple—Syphilis—Hereditary Syph- ilis—Sarcoma Cutis Hæmorrhagica.	
PHILADELPHIA DERMATOLOGICAL SOCIETY (November).....	40
Ulcerating Vascular Nævus—Transitory Benign Plaque of Tongue—Hypertrophic Lichen Planus—Case for Diagnosis—Dermatitis Repens—Cutaneous Atrophy—Epi- thelioma, Extensive—Eczema Sehorrhoicum Resembling Lupus Erythematosus.	

REVIEW OF DERMATOLOGY AND SYPHILIS.

BACTERIOLOGY AND PARASITOLOGY	43
Dermatitis of Ground Itch, the Causative Factor in the Production of the, C. A. Smith—Dermatomycosis of the Non-hairy Regions in Man Caused by the Micro sporon Canis, Nicholas and Lacomme—Microsporons, Recent Research Concerning the, Sabouraud.	
Treatment of Vascular Nævi by Radium. Wickham and DeGrafs.....	45

BOOK REVIEWS.

A Handbook of Skin Diseases and Their Treatment. ARTHUR WHITFIELD, M. D., F. R. C. P. (Lond.).....	47
Text-Book of Diseases of Skin. ARTHUR VAN HARLINGEN, Ph.B (Yale), M. D.....	48



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THE JOURNAL OF CUTANEOUS DISEASES

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JANUARY, 1908.

No. 1

OSTEOPATHIES OF QUATERNARY SYPHILIS.

By PROFESSOR GAUCHER and Dr. LEVY-BING, Paris.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

IN a former paper,¹ one of us showed that tertiary heredo-syphilis may produce suppurative bone lesions, absolutely similar clinically to tuberculous osteitis, and whose diagnosis can be established only by the rather quick curative effect of specific treatment.

The aim of the present paper is to show that *quaternary heredo-syphilis*, or *para-heredo-syphilis* may also engender bone or joint lesions, generally mistaken for the tubercular lesion of same aspect; or, at least, that those bone and joint lesions exist with incomparable frequency, in subjects showing undeniable heredo-syphilitic dystrophies.

Children, bearers of tuberculous arthritis, hip, or Pott's disease, are very often, we shall even say almost always, first or second generation descendants of syphilitics. In order to confirm this opinion, we systematically examined the children presenting suppurative bone lesions treated in Berck-sur-Mer hospitals and we were surprised at the really strikingly high percentage of heredo-syphilitics we came across.

We first went through, thanks to Dr. Ménard's kindness, a few wards of Berck's Maritime Hospital where children, boys and girls, afflicted with tubercular osseous lesions (hip disease, Pott's disease, white swellings, etc.), are treated. We were impressed, from the start, by the considerable number of heredo-syphilitics whose typical facies draws the eye: saddle nose, nose "*en lorgnette*," prominent (so-called olympic) forehead, very developed and very apparent veins of the forehead and temple, natiform skull, deformed auricle, etc., etc. A closer examination of the same children enabled us to detect other cranial, dental, palatal, ocular and bony dystrophies.

¹ Suppurative osteitis and osteoarthritis of tertiary heredo-syphilis. Prof. Gaucher, *Annales des Maladies Vénériennes*, T. II., No. 1, Aout, 1907.

All varieties of dystrophies are exceedingly common, either gathered all in the same subject, in whom they so abound that no room is left for any doubt as to specific heredity, or more scattered, two or three only existing, but still sufficient to enable us to affirm the specific origin of the bearers. Not unfrequently does heredo-syphilis show but one stigma, but we did not consider as syphilitic children having only one manifestation, even when the latter was as pathognomonic as a saddle nose; this, in order to avoid the easily formulated objection that we counted as syphilitic patients who did not present undoubted evidence of the disease. However, we know that even a very thorough and very attentive examination sometimes fails to elicit the least dystrophy in undeniably heredo-syphilitic subjects. Therefore we included in our statistics only those children having at least three stigmata, for instance: dental alterations, a saddle nose, and fronto-temporal venous ectasies. We have voluntarily left aside those having only one or two defects, even, when under the other circumstances, the latter would have been sufficient to warrant a diagnosis of heredo-syphilis. We do not want to draw down upon us the reproach of seeing syphilis and syphilitic heredity everywhere; and it follows that our figures are far below the reality.

In Berck's Maritime Hospital, we examined 153 children taken at random, 71 boys and 82 girls. Among those, we found 30 (10 boys and 20 girls) presenting all the features of heredo-syphilis. Ten were under treatment for Pott's disease, 15 for unilateral, either right or left, hip disease, 1 for double hip disease, 1 for white swelling of the elbow, 2 for white swelling of the wrist, and 2 for suppurative cervical adenitis. The age varied, for the boys, of from 28 months to 7 years, and, for the girls, of from 3 to 12 years.

We are indebted to Dr. Calot for a thorough visit of the Oise hospital.² There we examined all the patients, 94 in number; 70 ranging from 3 to 12.5 years (32 girls and 38 boys); and 24 above 12.5 years (12 boys, 12 girls). Among those 94 patients, we found exactly 38 showing very numerous stigmata of heredo-syphilis; said stigmata being in some cases so complete and so multiple that the bearers might have been considered as real types of specific heredity.

Among the 70 children of the younger class, there were 13 heredo-syphilitic girls and 22 boys; of the 24 older, there were only 3 heredo-syphilitics, all boys. None of the 12 girls presented sufficiently characteristic or numerous dystrophies for us to place her on

² We desire to express our thanks to Dr. Calot's assistants, Drs. Michel and Privat, for their courtesy and for the readiness which they displayed to make our task easier.

our list. All these children were under treatment for some of the following conditions: hip disease (among which were 2 suppurative cases), Pott's disease (among which 1 fistulous case), tubercular osteo-arthritis, arthritis of the ankle joint, osteitis of the tibia and suppurative gummata of the buttock.

We also went through Dr. Calot's Orthopedic Institute and through the Cazin-Perrochaud Hospital. There, also, we noticed the great number of heredo-syphilitics in the wards, but we did not study their lesions in detail. Besides, the figures we collected in the two Berck hospitals we just mentioned (Maritime hospital and Oise hospital), are enough for the present time to demonstrate what we want to prove, viz., the extreme frequency of tuberculous bony lesions in quaternary heredo-syphilitic subjects.

The diagnostic elements derived from the family of the patient, either direct ascendants or collaterals, we missed altogether in our inquiry; just as we miss them in most hospital cases. Those supplied by the patient himself are the only ones we could have and use. And yet, in many cases, we could not take into account the previous history, because many of the children were too young to answer our questions in a useful manner and to give us some information on the accidents and morbid peculiarities of their infancy. In those cases, direct examination enabled us, much better and much more safely than any memory data, to make a diagnosis of heredo-syphilis. All patients included in our statistics presented simultaneously diversely allied and very numerous dystrophies which are summarized in the following table:

1—*Skull and face:*

Olympic forehead.

Cranial asymmetry.

Saddle nose.

Ogival or very deep round palate.

These are extremely frequent; the following are less and are placed in order of decreasing frequency:

Dolichocephaly.

Malformation of the auricle.

Prognathism of lower jaw.

Transverse widening of skull.

Natiform skull.

Hydrocephalus (2 cases.)

Harelip (1 case.)

2—*Teeth:*

Asymmetry, defective orientation, amorphism.

Microdontism.

Abnormally distant teeth.

"Screw-driver" teeth.

Multiple and systematized dystrophies of the crown, corrugated and striated teeth, all very frequent lesions.

Absence of upper canines or incisors (2 cases.)

Atrophy of the crown of the first large molar (2 cases.)

Typical Hutchinson's tooth (2 cases.)

3—*Venous system*:

Dilatation of the veins of the forehead, the temples, or the root of the nose, where they form a very developed and prominent network. We found such an hypertrophy of the venous system in a great number of patients.

4—*Joints and bones*:

Exostoses and hyperostoses.

Thoracic deformities.

Deformities of the limbs (genu valgum, epiphyseal nodosities.)

Deformities of the spine.

The foregoing are very common. The following are rarer:

Chronic hydrarthrosis.

Deforming arthropathies (4 cases.)

Congenital hip dislocation (3 cases.)

Dactylitis (2 cases.)

Multiple spinæ ventosæ of both hands (1 case.)

Club foot (1 case.)

Club hand (1 case.)

5—*Eyes*:

Active interstitial keratitis (1 case.)

Double convergent strabismus.

Professor Gaucher insists particularly on the value of the latter as a symptom of heredo-syphilis. Now, we found it, more or less marked, in 44 out of our 68 heredo-syphilitic children. We shall not dwell any longer on that so common and little known stigma, which Dr. Antonelli has studied, in an article published in the Feb., 1907 issue of the *Annales des Maladies vénériennes*.

It would have been also very interesting to perform ophthalmoscopic examinations of the fundus, in all the children under consideration, and we feel sure that a systematic examination of all fundi, even of children apparently free from all dystrophies, would have discovered still a number of heredo-syphilitics whom we did not even sus-

pect; because ocular lesions exist often alone and unassociated with any other hereditary dystrophy; and also because they are among the most frequent. Fournier says they exist in 43% of cases, and Edmond Fournier raises the ratio to 48%. Now, those lesions are precisely those we could least observe, for we have not made any ophthalmoscopic examinations, and barring the cases of strabismus and a few scars of interstitial keratitis, we did not look for ocular symptoms.

Consequently our statistics sin rather by omission than by excess. Summing up, in 247 patients examined, we found 68 tainted with hereditary syphilis. There is a long step between this and the conclusion that all tuberculous lesions presented by those children have a syphilitic origin; but such a frequent occurrence of tuberculous lesions in children showing all the stigmata of specific heredity must be noted and we cannot but be impressed by the comparison.

Of course, our study lacks one element, namely, therapeutic proof. It would have been necessary to submit those children, especially those with suppurative lesions, to a specific course of treatment with soluble mercurial injections and potassium iodide. We can, however, quote a personal case, in which a child presenting *none* of the stigmata of hereditary syphilis and bearing a fistulous Pott's disease, had her lesions very favorably modified by hydrargyric medication. The case is as follows:

Female child, three years old, always in good health, without any hereditary marks, born of a healthy mother and of a formerly syphilitic father, treated during three or four years with pills and injections of gray oil. In January, 1906, the child developed suddenly a very painful wry-neck on the right side; after two weeks rotation and flexion of the head became impossible. The symptoms were at first ascribed to rheumatism and treated with liniments and by rubbing, the pain, however, increasing steadily and motion becoming more and more limited. The parents sought the advice of a surgeon who diagnosed a tuberculous cervical arthritis. The little patient was treated accordingly (over-feeding, cod liver oil, syrupus ferri iodidi, immobilization). But the arthritis, instead of improving, grew worse and soon opened in the cervical region through a long, profusely suppurating, sinus. The latter was cauterized, scraped, dressed during a certain time; and then, viewing the uselessness of all attempts, we prescribed mercurial inunctions, 4 grammes daily, supplemented by potassium iodide. A first course of 15 inunctions was given; next month, 15 others were given and during the resting interval, the child took 1 gramme potassium iodide daily. Under

the influence of that energetic treatment, the secretion was modified very rapidly, the sinus healed progressively, pain disappeared entirely, movements became free again; the general condition improved and the child regained the splendid complexion she had before. However, immobilization was still kept up.

Many such lesions, although manifestly syphilitic in their origin, are not amenable to mercurial medication, because they belong to quaternary heredo-syphilis. There lies precisely the difference between tertiary heredo-syphilitic osteitis and quaternary heredo-syphilitic osteopathies; the former are cured quickly and permanently by the specific treatment, while the latter are little or not at all modified by the same.

But, anyway, even if there are no symptoms, even if a direct examination or search in the previous history does not give any definite clue as to hereditary syphilis, it may be beneficial (and there is no inconvenience in it) to administer mercurial treatment in doubtful cases, if any symptomatic abnormality leads us to suspect syphilis. Sometimes, unexpected cures will obtain, or, at least, favorable changes in the ground on which an osteopathy develops, the diagnosis of which will have been enlightened by the coexistence of other dystrophies.

We conclude, therefore, that heredo-syphilis, either directly or in the second generation, is an important factor in the production of suppurative bone and joint conditions of childhood; white swellings, hip and Pott's disease; whether the lesions be directly dependent on quaternary heredo-syphilis or whether hereditary taint be only a capital predisposing cause for tuberculous lesions.

Translation of this paper kindly made for the JOURNAL OF CUTANEOUS DISEASES, by Dr. Faxton E. Gardner, New York.

ERYTHEMA EXUDATIVUM MULTIFORME, ITS PRESENT
SIGNIFICANCE—WITH A REPORT OF A CASE OF
ERYTHEMA CIRCINATUM BULLOSUM ET HÆMOR-
RHAGICUM, FOLLOWING A GUNSHOT WOUND, AP-
PARENTLY DUE TO STEPTOCOCCUS INFECTION
AND TERMINATING FATALLY.

By WILLIAM THOMAS CORLETT, M. D., Cleveland, Ohio.

Read before the Sixth International Dermatological Congress, New York,
September 9, 14, 1907.

THE first step towards grouping the objective manifestations of erythema¹ was made by Hebra in 1854.² Previous to this time the various forms delineated by Willan³ in 1808, were accepted and treated of as distinct affections. It is true other observers had paved the way, for in 1835 Rayer⁴ cited cases collected by Bonnet in which several varieties of erythema were seen on the same individual.

Hebra observed that the various types of the erythemata as portrayed by Willan and Plenck,⁵ often changed from one form to another and occasionally several types were found coexisting. "In reference to this point," he writes, "experience has taught me that the erythema papulatum, erythema tuberculatum, erythema annulare, erythema iris, erythema gyratum, are merely forms of the same disease in different stages, the appearance varying according as the affection is undergoing development, or in a later period of its course, or subsiding. To this malady I shall apply the name of erythema multiforme."⁶

The erythema multiforme as recognized by Hebra was a clearly defined affection running a self-limited course in from two to four weeks, although subject to recurrence.

In 1876 Lewin⁷ collected a number of fatal cases of erythema multiforme and maintained that the conception of the affection then held, was too circumscribed, and that certain cases presented the characteristics of an infection. For these he proposed the name erythema exudativum.

Uffelmann⁸ also reported cases to substantiate this claim.

The cases thus described were not generally recognized as indubitable instances of erythema multiforme, nor were the conclusions derived therefrom generally accepted. Both Kaposi⁹ and Schwimmer,¹⁰ while recognizing a bullous form and extending the boundaries of the affection as outlined by Hebra, still insisted that the disease adhered to a definite type, self-limited in its course and terminating in recovery. The former proposed the name erythema polymorphe. This view has largely obtained both in England and America. Thus Crocker¹¹ while describing in full the various forms erythema multiforme may assume, does not attribute its occasional fatality to the erythema, but to the diseases with which it is concomitant. The most recent works on dermatology in this country, that of Hyde and Montgomery (1904), Stelwagon (1905), and Pusey (1907), while enlarging the domain and portraying a variety of clinical manifestations under this caption, still maintain a clearly defined boundary and benign character of the disease.

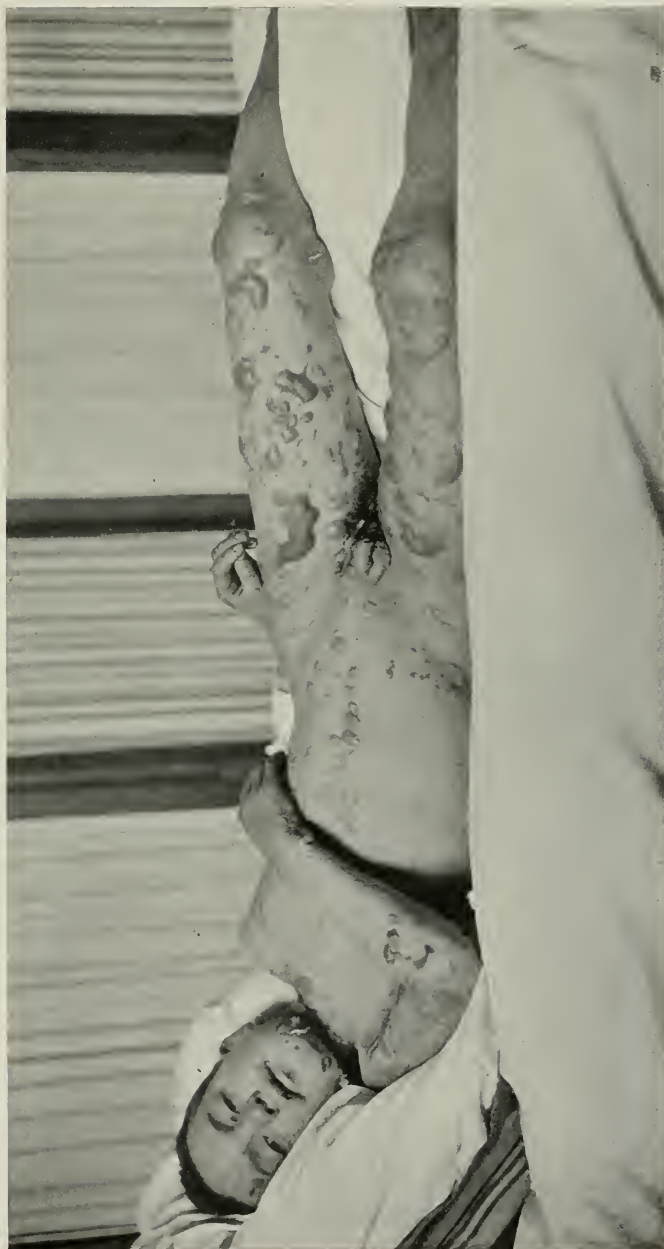
Osler¹² studying erythema multiforme from the viewpoint of general medicine, regards it as a symptom, not always present, of various diseases of the internal viscera.

In France the almost limitless variety of clinical manifestations that erythema multiforme may assume has long been recognized. In 1835 Gibert¹³ wrote that erythema may be symptomatic, due to derangements of the internal viscera, and the following year Rayer spoke of arthritic fever and cutaneous hæmorrhages in connection with erythema, but drew a sharp distinction between the erythematous and bullous dermatoses.

Besnier and Doyon,¹⁴ not only agree with Lewin and Uffelmann that erythema multiforme may pursue a malignant course, but further speak of it as a disease, if disease it may be called, that defies definite classification, an affection of almost infinite variety of clinical symptoms, and under whose cognomen new forms occur from time to time in the observation of the most experienced clinician.

Since the beginning of the eighteenth century it has been associated with various diseases, notably purpura, rheumatism, urticaria and pemphigus, until the clinical line of demarkation at times between them is not clear. The cases reported by Mackenzie,¹⁵ Osler, Fayrer¹⁶ and Wright¹⁷ go to strengthen the claim of this relationship. On the other hand it has also occurred in connection with such definite affections as gonorrhœa, syphilis, tuberculosis, pneumonia, enteric fever, leprosy and Bright's disease. While more

PLATE I—To Illustrate Dr. W. T. Corlett's Article.





recently Galloway and MacLeod¹⁸ have associated it with lupus erythematosus.

While it is disconcerting alike to the student and to the clinical teacher, yet we must admit that the definite limitations of erythema multiforme are at present unknown. Nor can we hope for a clear elucidation until the *fons et origo* of the manifold symptoms which constitute what we call erythema multiforme are better understood.

As in classification so in etiology and pathology the great problem relating to erythema multiforme has apparently repeatedly been solved. In 1864 Köbner,¹⁹ followed by Auspitz,²⁰ and Schwimmer endeavored to establish it as an angioneurosis due to vasomotor disturbances. In 1876 Lewin, and later Molènes Mahon²¹ added primary infection as a cause, to which Vidal and Leloir ascribe certain cases. Ptoxic poisoning or the toxins from faulty metabolism have been assigned an important etiological rôle by Chaisse,²² Legendre,²³ and Galloway.²⁴ Cordua²⁵ and Luzzato²⁶ found micrococci in the blood, and Haushalter²⁷ a streptococcus, Leloir²⁸ both a diplococcus and a streptococcus, while Finger²⁹ attributed some cases of erythema multiforme to the local effect of bacteria. Later in writing of the cases of erythema nodosum, purpura rheumatica and epidemic zoster, Kaposi³⁰ says:

1. Certain typical cases which occur annually lead us to infer a miasmatic infection or bacterial origin.

2. Sporadic cases are generally a reflex effect of some anomalous condition of the internal organs, as in amenorrhœa, dysmenorrhœa, uterine displacements, etc. Such cases are pure angioneuroses.

3. Some may be due to autoinfection with toxic substances which have entered the blood as the result of internal disease, such as tuberculosis, nephritis associated with inflammation, suppuration and malassimilation.³¹ Besnier and Doyon³² say: while there may be an infectious element, it is subject to extreme variations and is influenced more by the individual predisposition than by any specific property of the *materies morbi*. It is further evident that erythema multiforme may arise from various causes, but whatever the cause its action is on the vasomotor centers rather than on the skin direct.

In cutaneous hæmorrhages which are so frequently associated with the exudative erythema, Howard³³ has recently demonstrated in a number of cases a diplococcus in the blood which somewhat resembles the pneumococcus although differing from this organism in certain details and corresponding to that previously found in

hæmorrhagic infections by Banti,³⁴ Babès and Oprescu,³⁵ and von Dungern.³⁶

From the foregoing it is evident that our knowledge of the affection under consideration is in a transitional stage, and any light thrown on it is greatly to be desired. In this connection the following case presents certain striking features:

J. H., male, aged twelve years, with a negative family history, was said to have been a healthy, well developed child at birth. At four months of age he had an abscess in the throat of which the details are unknown, at three years of age he had pneumonia, and at eight diphtheria, in which antitoxin was given. After convalescing from diphtheria, an illness occurred which the mother said was brain fever; she also mentioned what might be malarial fever as occurring about this time.

According to the mother, the child has always been subject to febrile attacks lasting a day or so, during which a slight delirium was often present. Three years ago he visited the Nose and Throat Dispensary at Lakeside Hospital with enlarged tonsils and palpable glands in the neck. Tonsilotomy was advised, but declined. In recent years there have been frequent attacks of tonsilitis. During the year preceding the illness the child had enjoyed unusually good health.

On May 5, 1906, he was struck behind the left ear with a shot from a Flobert rifle. This was dressed at the Surgical Dispensary of Charity Hospital, and no apparent infection followed. May 12, seven days later, he returned complaining of pain in the ankles. Examination revealed both ankles swollen, one red with some increased local heat, and a general temperature of 102° F. Examination otherwise negative. The following day he was seen by an outside physician, called on account of an eruption covering a greater part of the body, and said by the physician to be a simple urticaria. On the following day, May 14, he was seen by Dr. W. H. Merriam, physician at Charity Hospital Dispensary, to whom I am indebted for the notes of the case previous to my examination, who reported him sitting on a chair unable to walk on account of pain in the ankles. At this time the entire body was covered with an erythematous eruption, and about the ankles, which were slightly swollen, was a marked degree of cyanosis. On the neck were a few small bullæ containing a transparent, serous fluid. He was then admitted at Charity Hospital. Temperature on admission was 102. Physical examination was negative with the exception of a slight roughening of the systolic tone at the apex of the heart. Two days later, May 16, the case first came under the observation of the present writer.

The erythema was of a circinate or gyrate variety, with pinkish, apparently elevated margins enclosing a lighter colored central area, best seen on the trunk and adjacent parts of the extremities. In some places, notably on the buttocks and lower extremities, the erythema assumed a darker hue which pressure with a glass slide did not wholly remove. There was also a few petechiæ and a number of bullæ varying in size from two to six cm. in diameter, most abundant on the neck and upper part of the trunk, although no region of the body was wholly exempt.

The subsequent course of the eruption was as follows: From day to day the erythematous patches gradually became bullous, first containing a translucent, serous fluid, which soon took on a cloudy, opaque color, and finally became hæmorrhagic. As the eruption developed, the pain in the joints subsided. On May 23, many of the bullæ had become purulent, and on the evening preceding, the temperature, which from the second day in the hospital had remained about 99°, suddenly rose to 101°. On this day the bullæ were opened to allow free drainage, and the patient was kept in a mild antiseptic bath. Blood culture was attempted on May 23, but on attempting to pass the needle into the median basilic vein, it was found that the skin was so full of minute vesicles that it would be impossible to obtain a sterile culture. Cultures from both the purulent and hæmorrhagic bullæ gave pure streptococcus growths.

On the afternoon of May 24, the boy developed symptoms of failure and died that night. There was some doubt as to the actual cause of death; it seemed, however, that it might be due to absorption of septic material from the skin lesions, as there was quite a large area of denuded surface.

The post mortem was made by Dr. J. D. Pilcher, pathologist to Charity Hospital, on the following morning. The result of this examination was entirely negative with two exceptions herewith noted. About the spleen were numerous old fibrous adhesions possibly due to one of the earlier infections, perhaps the pneumonia. The gross appearance of the spleen was not at all that of a septicæmia. The structure was more, rather than less, dense than normal. On opening the stomach, an area near the pylorus was discovered with small hæmorrhagic spots. It was suggested that such appearance might have been due to post mortem changes, but the distinct limitations of the area involved in these spots rendered this untenable. Quite close to the cardiac orifice was an area about 3 cm. in diameter which showed denudation of the gastric epithelium.

The histological examination was made by Dr. Oscar T. Schultz of which a synopsis may be given as follows:

The internal organs show nothing further than the changes

previously noted, except that attention should be called to the presence of cloudy swellings in the liver and kidneys.

Skin Lesions: The epidermis is entirely absent and the surface of the cutis is covered with a thin layer of necrotic material. The connective tissue fibres beneath this layer have a swollen, opaque, rather hyaline appearance. The blood vessels of the cutis are markedly distended, and the accompanying lymphatics are filled with pus cells. Infiltration by inflammatory cells does not occur in the tissue of the cutis. The chief change in the deeper tissue of the skin is limited to the blood vessels and lymphatics. This change is associated with a loss of epidermis and a superficial necrosis of the cutis. The inflammation is of the exudative type, rather than of a proliferative or infiltrative nature. It is the type of inflammation that is often associated with a vascular and lymphatic localization of the streptococcus.

Examination for bacteria shows numerous Gram positive cocci, usually arranged in pairs, in the superficial necrotic zone. Since bacteriological examination of the fluid of the bullæ gave pure cultures of streptococci, one is safe in asserting that the cocci seen in sections are of the same species. Occasional cocci are seen in the deeper tissue spaces. Here and there one can see a coccus in a dilated blood vessel. And in a lymphatic filled with pus cells cocci are fairly numerous. In a number of the distended blood vessels fibrin is present and the vessels are apparently thrombosed.

From the histological findings there are two possible deductions.

1. That the inflammation of the skin is entirely independent of the gun-shot wound, and is due to a primary infection of the skin by the streptococcus.

2. That infection by the streptococcus occurred by way of the wound, that the skin inflammation is secondary to such an infection, and that the case is one of generalized infection with particular localization of the organisms in the skin.

The second possibility seems much the more probable for the following reasons:

1. The involvement of the skin is so general as to preclude an infection of the skin from without and a spread of the inflammation in the skin from a primary point of skin infection.

2. The involvement of the deeper vessels of the cutis would indicate an infection of the skin by way of the general circulation.

3. The superficial exudation and loss of epidermis seem to be secondary to the vascular involvement.

4. It is known that generalized infection, particularly by very

virulent strains of streptococcus can occur without very marked changes at the point of entry. Death may result rapidly, due to localization of the organisms at some point widely removed from this portal, or death may occur even before there is time for a reaction on the part of the tissue elsewhere. Examples are not wanting of a generalized infection by way of the peritoneum without any apparent peritoneal involvement, and also infection by way of the pregnant uterus.

5. The gun-shot wound offered an ideal portal of entry.

For the reasons given above it would seem that the case ought to be grouped with those exudative inflammations of the skin in which the skin involvement is secondary to and part of a generalized infection.

I conceive, the report continues, the mechanism in the production of the bullæ to be as follows: Marked exudation due to vascular dilatation, the dilatation being caused by the action of the inflammatory agent upon the blood vessels. Interference with the drainage of the exuded fluid, because of a filling up of lymphatics by inflammatory cells and because of thrombosis of some of the veins. Necrosis of the epidermis following the exudation and the production of bullæ.

In conclusion: While the case from a clinical view point is comparatively infrequent, it is by no means unknown as the cases reported by Sherwell,³⁷ Osler, Galloway,³⁸ Blair,³⁹ King Brown⁴⁰ and others affirm. Neither are cases wanting in which an erythematous eruption followed by the formation of bullæ, hæmorrhage and death, occurring soon after and attributed to some local disturbance or traumatism. In this group the cases of Crocker,⁴¹ Welanders,⁴² Norman Walker,⁴³ Crawford⁴⁴ and others belong. Again, somewhat allied, may be the bullous dermatoses of Howe⁴⁵ after vaccination, Bowen⁴⁶ associated with foot and mouth disease in cattle, and the series of cases, mostly in butchers, reported by Pernet.⁴⁷ It is distinctive, however, in owing its possible origin to a gun-shot wound, and the histological findings seem to warrant its being classed as a streptococcus infection. Clinically it answers to what is now understood as erythema exudativum multiforme.

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NOTE ON A CASE OF SARCOID.

By S. POLLITZER, M. D., New York.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

SINCE the first publication by Professor Boeck, of Christiania, describing a new disease under the title of multiple benign sarcoid of the skin, the observations of that disease have multiplied to a sufficient extent to show that the condition is not one of such rare occurrence as its late discovery would seem to indicate. So, for instance, in his latest publication on the subject, Boeck is able to record ten personal cases, while in France, counting in the subcutaneous variety of the same disease described by Darier, nearly as many cases have been noted. Publications on this subject, however, from other countries—Germany, Austria, Italy, America, etc.—have recorded very few cases, or have been wanting altogether. It would seem unlikely that the disease is so much more frequent in Norway and in France than in other parts of the world, and it is reasonable to attribute the paucity of the reports to a lack of acquaintance with the disease. From this point of view alone my case would be worth noting; it appears to me particularly to merit a record, because it presents some unusual features.

The patient, a married woman, thirty-five years old, is well nourished and healthy looking; but when she first consulted me she had just returned to New York after a prolonged residence in a sanatorium in the Adirondack Mountains, where she had gone on account of a tuberculosis pulmonum, which had advanced to the formation of a large cavity in the right lung. The cutaneous affection began about five years ago with the sudden appearance of bright and dull red, round or oval, slightly elevated areas from 5 to 20 mm. in diameter, with flat normal surfaces and sharply defined border; no subjective sensations. On palpation these plaques give the impression of moderately firm infiltrations in the cutis, which is freely movable over the subcutaneous tissues. From their first appearance to the present time they have remained practically unchanged, except that during the first weeks after their occurrence many of them in-

creased slightly in area. New patches, however, have appeared from time to time up to six months ago, since when there has been no fresh eruption. The plaques are located in the face, forehead, cheeks and nose, the neck, shoulders, the left arm, both forearms and wrists, the abdomen and the right leg. In their distribution they show only an indifferent symmetry and no predilection for either the flexor or the extensor surface; so, for instance, at the right elbow there are two small patches on the flexor and two on the extensor side. There are in all about twenty-five lesions, and except one near the umbilicus and one on the right leg above the ankle, they are all located on the face and upper extremities. At the tip of the nose and on the alæ there is a group of five small lesions from 3 to 8 mm. in diameter which lately have shown a tendency to coalesce. The lesions in the face assume a bluish hue when the patient is exposed to the cold or has a spasm of coughing. Three of the larger plaques—one on the forehead, one on the left arm, one on the left wrist—show near their center a hemispherical prominence about 4 mm. in diameter, in appearance and to touch suggesting a soft mole (*verruca mollis*). None of the lesions show any scaling, none have shown any sign of atrophy; the inguinal and axillary glands are not notably enlarged, a blood count yielded nothing of interest.

In the diagnosis of the case lupus erythematosus, sarcoma and pernio were considered, but only to be rejected; and it was only after making histopathological studies and advising with Dr. Darier of Paris (to whom I desire here to express my obligations) that it became clear that we were dealing with a variety of Boeck's sarcoid. From this disease, however, my case differs in the following particulars:

The color of the lesions is bluish or brownish red rather than yellowish brown; there is no scaling, no central depression, no network of the dilated capillaries, and the very irregular outline with narrow raised yellowish border is absent; there are no yellowish pin-head lichenoid papules; there are no large packets of lymph-nodes.

The study of an excised plaque shows the lesions, however, to be identical in structure with the sarcoid of Boeck. This has been described so well by Boeck, and especially by Darier, that I shall pass over it briefly. The sections show larger and smaller cell masses, round or irregular in outline, lying in the cutis, which is characteristically free from any signs of reaction. These cell-masses are scattered through the cutis from the border of the subcutaneous fat up to the sub-papillary layer. In Boeck's cases much more massive cell

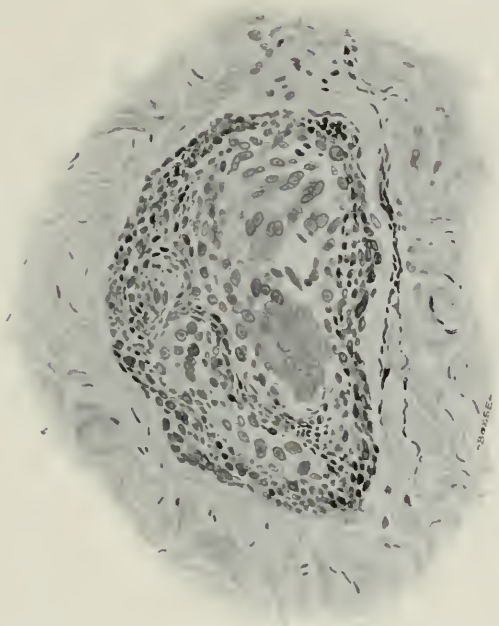


FIG. 1. SARCOID:—A sharply circumscribed "Tubercle" in middle cutis, showing giant, epithelioid, and lymphoid cells.

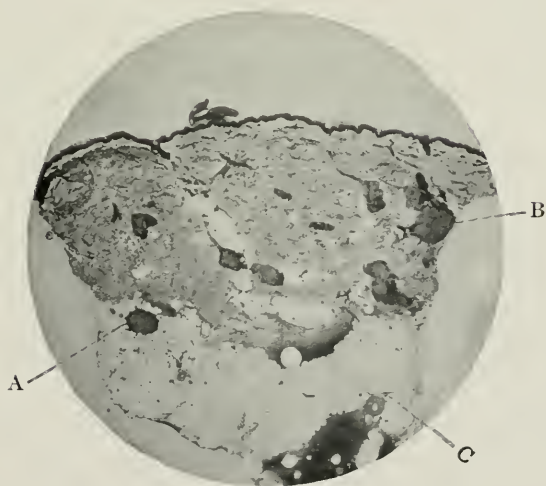


FIG. 2a.

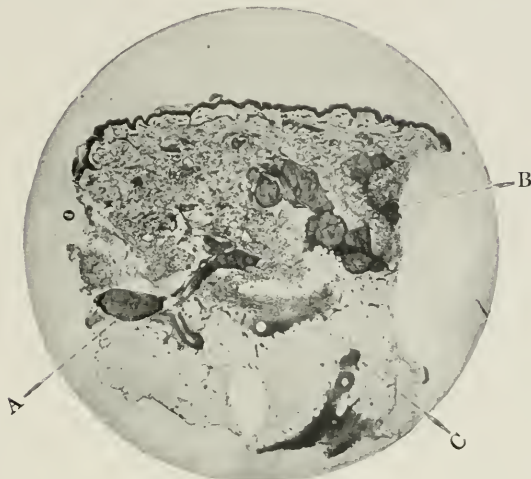


FIG. 2b.



FIG. 2c.

aggregations are described than occur in my case, and they are located, as a rule, rather high in the upper layers of the cutis. I find these cell masses in relation to the larger vessels occupying a peculiar position; they are usually located on one side of the vessel, seldom surrounding it. In detail these cell masses consist of epithelioid and lymphoid cells, with a few giant cells. (Fig. 1.) Many of the smaller masses present a picture strikingly like that of tubercle, so that one can realize the force of Darier's statement, that if this be not tubercular tissue, he would not know what to call it. And yet the most careful search for tubercle bacilli yielded no result, and injections of a suspension of a large part of the excised plaque into the peritoneal cavity of three guinea pigs provoked no tuberculosis in them.*

For the purpose of determining the mutual relations of the cell masses in the cutis a portion of the excised plaque was cut in serial sections. I show you here three views (Fig. 2, a, b, c), approximately from the beginning, middle and end of the series. The small oval infiltration at the subcutaneous border on the left of the first section may be traced obliquely across the field in the successive sections till it merges into the larger mass of cells in the upper cutis on the right. Similarly, the small infiltration near a large vessel in the sub-cutis on the right of the second section gradually passes up to unite with the same mass above it. It seems to me likely, therefore, that all the various round, oval, or irregular masses of cells which constitute the new tissue, widely scattered as they appear throughout the cutis, are simply irregular ramifications of one extensive infiltration shaped like the twisted and gnarled root of an old tree with its fantastic tuberosities and outrunning branches.

We are in the habit of regarding a tubercle as an approximately spherical mass. I am in some doubt as to the bearing which the peculiar shape of the irregular infiltration I have described will have on the theory of the relation of the cutaneous process to a distant tubercular focus. A large number of these cases of sarcoid present evidences of tuberculosis, or at least respond positively to the tuberculine test. You are aware that Boeck has accepted the identity of his sarcoid with the disease described by Darier as *lupoide en disques*, and has agreed with him in regarding it as a tuberculide.

To sum up the points of this brief communication, we have:

1. A case presenting clinically the essential features of Boeck's sarcoid, but differing in some notable respects, occurring in a woman highly tubercular.

* The histological work in this case was done in the Pathological Laboratory of the Mt. Sinai Hospital; the animal experiments in the Research Laboratory of the N. Y. Department of Health.

2. Histologically the case presents a picture almost identical with Boeck's sarcoid and Darier's subcutaneous sarcoid, but differing from the former in extending quite uniformly throughout the entire cutis, and from the latter in its virtual absence from the subcutis; in this respect it may be described as an intermediary form.

3. The cell-masses on section strikingly resemble tubercle, but the various sections appear to be different parts of a single, or, at most, a few widespread irregular infiltrations, for the most part following the blood-vessels. Tuberculosis is excluded by the absence of bacilli and the result of experimental inoculations.

MULTIPLE BENIGN CYSTIC EPITHELIOMA.

BY M. L. HEIDINGSFELD, M. D., Cincinnati, Dermatologist to the City Hospital of Cincinnati.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

THE subject of multiple benign dermatologic new-growths is enveloped with considerable more haze than the long line of careful clinical observations, and pathologic investigations seemingly warrant. This haze which was notably absent from Kaposi's earliest classical description of lymphangioma tuberosum multiplex in 1892 has materially increased with the successive investigations of Jacquet and Darier on hydradénomes eruptifs; Török, on syringo-cystadenom; Brooks, on epithelioma adenoides cysticum; Fordyce on multiple benign cystic epithelioma; Balzer and Menetrier adenoma sébacés; Pringle adenoma sebaceum, etc. This haze at least in a measure has been doubtless due to over-attention to minor clinical and pathological details, and has resulted in overwhelming this class of dermatologic affection with a mass of complexing synonyms.

From the earliest there has been a constant conflict of opinion among those in authority as to whether the cases thus far reported can be consistently divided into a number of distinct groups or collected with greater propriety and convenience into a single class. The three principal groups into which most of the cases have been readily placed are (1) Multiple benign cystic epithelioma, (2) Lymphangioma tuberosum multiplex, (3) Adenoma sebaceum, to which a possible fourth can be added, (4) Linear nævi. The clinical characteristics of these various groups have been sufficiently long and well established to permit their ready recognition, and in themselves

require but little comment. In multiple benign cystic epithelioma the lesions are usually small, pin-head to split-pea in size, glistening, translucent in appearance, yellowish, pinkish or bluish white in color, rarely ulcerated, but sometimes centrally depressed, situated for the most part on the face, principally at the root of the nose, cheeks, forehead, ears and chin, bilaterally symmetrical, but grouped. The cases are mostly hereditary, females, develop at puberty, and consist pathologically of masses of epidermal origin of irregular interlacing epithelial strands, broad angular in outline, giving off smaller strands, and interspersed with oval or roundish cysts containing colloid or cornified epithelium. The nodules develop slowly and after attaining a moderate development usually remain stationary in size. The lesions in adenoma sebaceum are very similar to those in multiple benign cystic epithelioma, but are usually more symmetrical in distribution, and reddish brown in color. The pathologic change is usually a hyperplasia of the sebaceous glands, which is by no means constant, as will be referred to later. Lymphangioma tuberosum multiplex is characterized by small roundish or oval lesions, pin-head to a split-pea or larger in size, firmly imbedded in the cutis and slightly elevated above the surface, irregularly but bilaterally distributed over the anterior aspect of the thorax and the fossa of the neck. Pathologically they are mostly endothelial in character, derived from lymph and blood vessels. Linear naevi, when linear in distribution, and unilateral in character are readily recognizable and require no special clinical comment, but when they occur in the form of multiple bilaterally distributed, discrete lesions, with a distribution analogous to the affections already enumerated, they can present clinical and pathological features difficult of differentiation.

All these groups present many common clinical and pathological characteristics. Most authorities concede to them an embryonic congenital origin from misplaced epithelial tissue. Most of them are stimulated by puberty to their greatest degree of new growth and development. The pathologic findings in each group are exceedingly varied, but group compared with group, possess much in common. They often present common clinical characteristics in size, color, stability, distribution of the lesions, and their hereditary and painless character. Their common though infrequent change to malignancy has also been noted. Most authors while still maintaining separate groups for certain clinical considerations, are frank to admit that they possess much in common to permit a unification and simplification of this particular class of dermatologic cases. Crocker¹ (p.

984), who is a strong advocate for the division of these cases into separate groups is frank to admit that multiple benign cystic epithelioma, lymphangioma tuberosum multiplex and adenoma sebaceum, possess many common characteristic traits; that certain clinical features which serve to distinguish them from each other possess merely relative value; that the microscope must often decide, and the pathology still awaits more common and general agreement.

Wilhelm in presenting a case to the Vienna Dermatological Society stated that "lymphangioma tuberosum multiplex is variously diagnosed as hydra-adenoma, hemangio-endothelioma, syringocystadenoma, etc., according to the pathogenesis from gland, blood or lymph vessel of the skin as determined by microscopical examination."

Dorst and Delbanco report a case of linear nœvus which they desire to class with multiple benign cystic epithelioma, and Gottheil, among many others in the literature, reports an apparent case from its clinical aspects of nœvus linearis or white mole of the scalp as an adenoma sebaceum.

REPORT OF CASES

G. C. G., aged sixty-five, came to my attention for the first time March 6, 1905. The nose (Fig. 1.) was the sit of about seventy-five small rounded or slightly pedunculated new growths, varying from pin-head to a split-pea or slightly larger in size, reddish yellow in color, inbedded in the cutis, non-sensitive to touch and painless to pressure, and situated mostly on each ala and the root of the nose. A number of smaller lesions were distributed over the forehead in

¹ Crocker states "that these cases (Multiple benign cystic epithelioma) resemble adenoma when abundant. The distribution and aggregation may be exactly like adenoma sebaceum, except on the forehead, where the growths are sparse in adenoma sebaceum, while in the other they are closely grouped for the most part. . . . In a few cases when the growths are sparse, the microscope would have to decide the question." In writing of lymphangioma tuberosum multiplex he states (p. 978), "Kaposi was the first to describe a case of this rare disease from Hebra's clinic, and the name he gave it stands at the head of this article on the score of priority, but not as representing the true nature of the growths, as it is worse than useless to change it until more general agreement is obtained regarding the pathology of this affection, than the farrago of synonyms indicates to be now the case." Again in a report to the London Clinical Society, he pleads for the separation of multiple benign cystic epithelioma and lymphangioma tuberosum multiplex, in spite of their many common characteristics, and in addition to a number of clinical and pathological differences of a relative nature, that the former is not hereditary and females predominate largely with the latter. In my own case of lymphangioma tuberosum multiplex herewith reported, the son inherited the condition from his mother, and in five cases of multiple benign cystic epithelioma, the father shared the affection with his two sons and two daughters.

PLATE IV—To Illustrate Dr. M. L. Heidingsfeld's Article.



FIG. 1.



FIG. 2.

PLATE V—To Illustrate Dr. M. L. Heidingsfeld's Article.



FIG. 3.

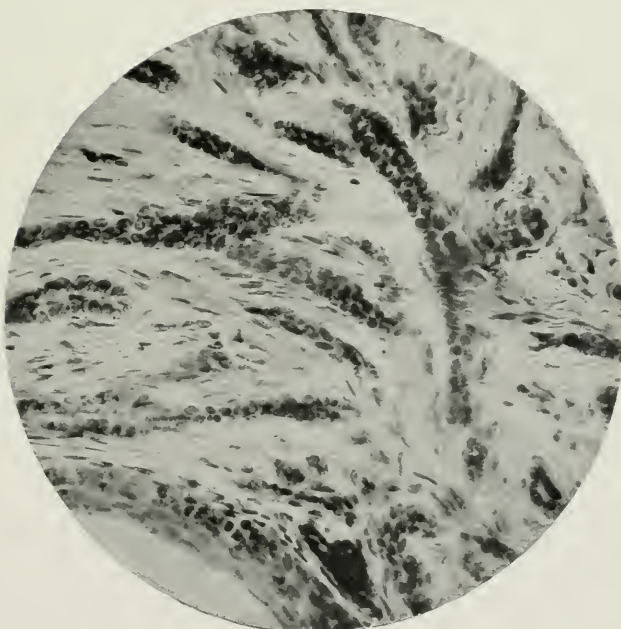


FIG. 4.



PLATE VI—To Illustrate Dr. M. L. Heidingsfeld's Article.



FIG. 5.

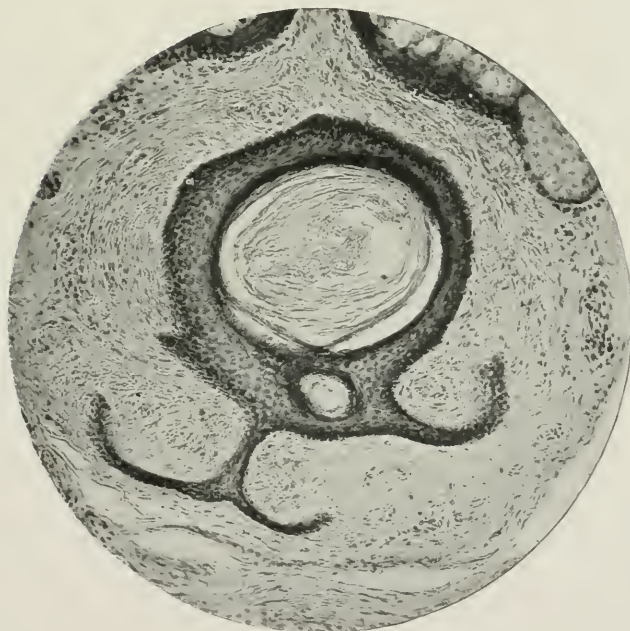


FIG. 6.



front and behind the ears, and over the chin. The tip of the nose, and the cutaneous surface of the septum were also the site of the lesions. There was no evidence of ulceration or active inflammation. Patient stated that the lesions first manifested themselves when he was about thirty years of age, and that they have steadily but slowly increased in size and multiplied in number. There was no history of any similar condition on his father's side of the family. His mother to his personal knowledge was free from the affection, but died before she reached the age of thirty. An uncle and an aunt on his mother's side of the family were similarly afflicted, and all of his children, two sons, aged thirty-four and thirty years respectively, and two daughters, aged thirty-eight and thirty-six years respectively, evidence the marked hereditary character of the affection. I am able to add my personal confirmation to the inherited traits in three of the children, and they show the same clinical and some of the pathological characteristics of the father. The affection began in all of the children on the nose, when they were from twenty-five to thirty years of age, and although the lesions at the present time are considerably smaller in size, varying from a pin-head to a good sized shot, they have the same distribution as that of the father, except in the second oldest daughter, the neck is also involved and the lesions show the same clinical and physical characteristics. The most striking feature of the cases is the fact that while nearly all the cases reported in the literature have occurred in females, in this instance four males and only three females were afflicted. These cases from three of whom, father, one son and one daughter, lesions were excised for histological examination, together with five other cases of multiple benign cystic epithelioma, form the basis of the pathologic investigation of this report. In one of the five remaining cases, Mr. B. P. M. (Fig. 2), aged sixty-five, the lesions were multiple, fifteen to twenty in number, glistening, translucent, yellowish white in appearance, some centrally depressed and situated underneath each eye, over the forehead, cheeks and chin. There was no progeny in this case and a history of heredity was unobtainable.

The microscopic examination revealed an abundance of interlacing epithelial strands and cysts. In the remaining cases the lesions presented the characteristic clinical appearance of multiple benign cystic epithelioma, but they were for the most part single and discrete, or consisted of a small group situated over a limited area of the face. All showed among other pathologic changes interlacing epithelial strands and colloid cysts. To these cases is added for comparative study a case of lymphangioma tuberosum multiplex of Kaposi in:

P. A. H., a full blood negro, aged twenty-five years, whose

anterior aspect of the thorax in a triangular area bounded by the nipples and the umbilicus, is studded by several hundred smooth rounded lesions, varying from a pin-head to a split-pea or larger in size, slightly elevated above the level of the surrounding skin, well imbedded in the cutis, more or less oblong in outline, with the long diameter running transversely with the long axis of the body. A group of about fifty of these lesions is situated above the clavicles and over the hollow of the neck, and four or five small lesions are over the left scapula. A few lesions have undergone an apparent spontaneous ulceration, and are the site of faint depressed cicatrices. The condition has been present as long as the patient can distinctly remember; but the lesions have slowly and steadily increased in size and number. Subjective symptoms have been uniformly absent. Patient who is married but without progeny states that his mother is similarly affected, but he has no personal knowledge of any other hereditary influences. The most striking clinical feature of this case, is the occurrence of the affection in the negro, the first to be recorded in that race, as far as my personal knowledge permits me to state, and its hereditary character, which is strongly denied by some authors. For further comparative study, is added a case of a rapidly growing hairy pigmented mole upon the chin of a young man, W. H. N., aged twenty-one, which took on active development at the age of puberty and showed upon histological examination some peculiar embryonic features. Finally, I wish to add a case which was diagnosed by its clinical features as adenoma sebaceum, and presented as such in Pusey's text book (Fig. 286, p. 866, 1907), Miss M. B., aged twenty-seven. This case was observed some seven years ago, into which a history of heredity was not inquired, and a diagnosis of multiple benign cystic epithelioma was not suspected. The patient has since passed from my personal observation, but personal recollection leads me to believe that a differentiation of these two affections in this case, without a well defined clinical history or a pathologic examination, would be difficult to effect.

PATHOLOGY.

The most striking, constant and characteristic pathological change in multiple benign cystic epithelioma (Fig. 3), is the well recognized and oft described interlacing epithelial strands, consisting of two rows of large oval nucleated epithelial cells here and there irregularly dilated by an apparent endothelial proliferation. These strands have a very irregular distribution, for the most parallel with or vertical to the surface of the skin. They possess many short bifurcations, and are of short irregular lengths (Fig. 4). Occasionally they are short, and usually broad, and end in three or more

short tail-like processes which gives them a peculiar stellate appearance. They are most freely distributed in the upper portion of the derma, near the papillæ, but often extend in greater or less degree into the lower depths of the cutis to the layer of subcutaneous fat. Their identity with the ducts or glands proper of embryonic misplaced or imperfectly developed sweat glands, has been often considered, but is a question to which I can add from my personal observations neither refutation nor confirmation. Sometimes, in the larger, longer-standing and more rapidly developing lesions, I have observed these bands to be unusually broad, and irregular in outline, containing masses of actively proliferating epithelium, with tongue-like processes extending from the borders, imparting to them a spread-tail-like appearance. In addition to these strands, there are a number of irregularly distributed round or oval cysts of varying size, with an epithelial wall of several or more layers of cells, with the contents mechanically removed or consisting of more or less concentrically arranged stratified epithelium or colloid material. In addition to these two usually most important changes, there is, as a rule, a secondary change in some other tissue element—a hyperplasia of the hair-follicles, connective tissue, sebaceous or sudoriferous glands, which is more or less constant for the lesions of each case. These features pertain principally to smaller lesions; in the larger, longer standing, more actively growing lesions, the original secondary hyperplasia assumes the primary rôle, and the adenoma sebaceum, sudoriparum, pili, etc., completely or incompletely overshadows the other pathologic changes. In the first group of cases, the father showed a marked hyperplasia of the hair-follicles in addition to the other characteristic changes. These structures were not only markedly increased in depth, circumference, and stratified contents, but gave off very peculiar-looking, single, occasionally branched horn-like processes. (This pathologic change has also been noted by Fordyce; p. 467.) The most striking pathologic change in the son's case was a marked proliferation of the connective tissue from masses of embryonic-looking cells. In the daughter's case, the chief secondary change was a marked hyperplasia of the sebaceous glands, which in the larger lesions resembled an adenoma sebaceum. This feature was also very marked in one of the cases where the lesions were few in number and circumscribed in area.

The chief pathologic change in the remaining cases is a very marked adenomatous hyperplasia of what apparently were original sweat glands, or possibly the interlacing strands of epithelial tissue,

which characterizes the condition. This adenomatous tissue is made up of large, rounded irregular masses, consisting of two or more rows of epithelial cells, arranged in columns, interlacing and closely grouped with more or less polygonal interstices of almost uniform size and distribution, corresponding to the cystic dilatation frequently observed in pathologically changed sweat glands and so-called cylindromata cutis. They are surrounded by a thin mesh-work of connective tissue, extending almost to the surface of the skin, and situated for the most part in the upper layers of the cutis. In many of the cases the interstices are longitudinally extended toward the surface, near the center of the adenomatous tissue, as if they corresponded or were derived chiefly from the ducts of the original glands. The cells showed active mitotic changes and extensive proliferation, particularly around the external portions of the adenoma, so that the borders of the larger lesions seem to be made up of a mass of conglomerate cells, devoid of any particular arrangement. In two of these cases, in addition to this change mentioned, the hair follicles in the immediate neighborhood show very extensive hypertrophic changes, so that they were many times increased in length and breadth, with their borders distinctly lobulated. In a few instances the central portion of the hair follicle corresponding to the site of the original hair was filled with a mass of epithelial debris, consisting of degenerated imperfectly keratinized and stratified epithelium. In others this area showed merely a clear space, indicating that the soft material had been mechanically removed by the knife on sectioning or had fallen away in the preparation of the specimen. The case of lymphangioma tuberosum multiplex showed a very peculiar anomalous condition, the analogy of which I have been unable to find in the literature, with the possible exception of Pollitzer's case, reported in the *Journal of Cutaneous Diseases* (vol. IX, p. 281). The lesions consisted of cysts surrounded by a wall of loose connective tissue and lined with a number of layers of epithelial cells. The larger cysts could not be hardened or sectioned with any satisfaction, the contents being mechanically removed with the knife on sectioning or falling away in the preparation of the specimen. The smallest lesions, pin-head in size, showed the cysts to be filled with a mass of degenerated, cheesy-looking epithelial debris and a large amount of small lanugo hairs, concentrically arranged in the form of locks. The lesions bear pathologic analogy to the dermoid cyst of the ovary, and in the absence of any evidence of hair follicles in the immediate neighbor-

hood of the lesions, they give strong evidence of their embryological derivation from misplaced epithelial tissue from the epiblast. All the lesions which could be sectioned with any satisfaction, and some fifteen or twenty were examined, showed identically the same change. None of the lesions gave any evidence of having been derived from the endothelium from the lymph or blood-vessels, and therefore this case of lymphangioma tuberosum multiplex is unique in its pathological character compared with those already reported in the literature. The case of pigmented hairy mole showed also a very anomalous and unusual pathological condition. On sectioning, it was noted that the knife encountered some extremely hard substance, which was at first thought to be calcareous material. Two microtome knives were practically ruined in obtaining very imperfect specimens from this case. While the sections were being cut, a number of very small, poppy-seed-size glistening bodies could be observed lying free upon the specimens and knife-blade, and a number were picked out from the gross specimen by means of a pair of tweezers. Examination of these bodies showed that they consisted of rounded masses of concentrically arranged laminated bone, which contained typical Haversian canals and bone cells. Under the microscope the tissue, in addition to the characteristic appearance of the ordinary piliferous pigmented mole, showed a number of these bony nodules situated in the lower layers of the cutis above the subcutaneous layer of connective tissue and fat. The specimens also showed a number of cavities from which these bony structures had been mechanically removed by the knife. This case is, therefore, classed with a very rare condition encountered in the literature, osteoma cutis, and gives additional evidence of the embryological development of some of these new growths from misplaced tissue, which in this instance must have been derived from mesoblast. (This and the preceding case will each form the basis for a subsequent report.)

GENERAL OBSERVATIONS AND DEDUCTIONS.

It is evident, therefore, that multiple benign cystic epithelioma, in common with lymphangioma tuberosum multiplex, adenoma sebaceum, and some of the forms of linear nævus present many clinical and pathological variations within these respective groups, and are sufficiently common to each other to materially prevent a sharp differentiation of these commonly considered dermatologic entities. Their development from embryonic misplaced epithelial or endothelial tissue is almost universally conceded to be one great point of

common resemblance, which should serve as a strong nucleus around which to gather other common traits for the elimination of any arbitrary division of these affections. Crocker, who has already been quoted as an advocate for the separation of these affections, states (p. 988) that adenoma sebaceum "is presumably an error of development in the shape of a congenital overgrowth of an adenomatous character developing from embryonic remnants in the skin, but in my experience affecting all the appendages, and therefore really a pilo-sebaceous hidradenoma." Again he states: "The two diseases (multiple benign cystic epithelioma and adenoma sebaceum) resemble each other. Indeed it would not be surprising if both these affections would turn out to be slightly different clinical expressions of the same pathological process." Walter Pick states that the clinical variations are marked, but the histological picture is so characteristic and marked as to permit both the diagnosis and differential diagnosis. A survey of some of the cases in the literature will readily reveal some marked clinical and pathological variations. Brooke's, Fordyce's, Fellander's, and Balzer's cases resembled clinically adenoma sebaceum. Derivation from the sweat glands was noted in the cases of Brooke, Darier, and Török; from sebaceous glands, by Pick and Balzer; from all the various structures, by White, Fordyce, Wolters, and Fellander; from hair follicles, by Jarisch; from the epidermis, by Csillag. Krzyształowicz states that the pathology of adenoma sebaceum consists of a proliferation of all organs and tissues of the skin in the most varied combination. He objects to its nomenclature and, together with Leredde, Pezzoli, Jadassohn, Dohi, Möller, Winkler, and many others, classes the affection with the naevi. Reitmann reports a case of adenoma sebaceum in which the chief pathologic change was a connective tissue hypertrophy poor in cells, rich in vessels, to which he attributed an embryonic development. Thin reports a case that was clinically a lymphangioma tuberosum multiplex, in which the lesions were derived from the normal sweat glands, which showed endothelial proliferation and cystic dilatation. Neumann, Blaschko, Unna, Philippson, Quinquaud, Török, share this same view in regard to the origin of their cases of lymphangioma tuberosum multiplex. Kaposi, Lesser, Kromayer, attribute the origin of their cases to lymph vessels; Wolters, Guth, Elsching, Jarisch, to blood-vessels, and Jacquet and Darier, to misplaced embryonic epithelial cells. The subject cannot be dismissed without consideration of the relation of these cases to malignancy. This feature has already received careful clinical impress at the hands of White and

Jarisch in the presentation of cases with ulcerative changes not far removed from those observed in malignancy, and with the comment that these cases have been observed and recognized too short a time to permit as yet a proper estimate of their terminal course. Fordyce has presented a very careful pathologic report of the affection and has recorded the striking analogy which exists in the pathology of these two affections. My personal observations in the pathology of multiple benign cystic epithelioma are a confirmation of those of Fordyce and I am frank to state that the advanced lesions of multiple benign cystic epithelioma not only show evidence of malignant change, but I have been able to find a parallel for them in every pathologic phase and form in the clinical lesions of early or pre-malignant change in the skin. This leads me to believe that malignancy, aside from prolonged irritating influences, has its focus in embryonic misplaced tissue, which is further confirmed by the oft-observed multiple excoriations, keratoses, and secondary ulcerations in malignancy of the skin, which are prone to take on the same malignant changes as the primary lesions, particularly if the latter are removed or favorably influenced by treatment.

CONCLUSIONS.

1. Multiple benign cystic epithelioma presents many clinical and pathological variations common to those of adenoma sebaceum, lymphangioma tuberosum multiplex, and some of the forms of nævus with discrete bilaterally distributed lesions.

2. All these enumerated affections present a common pathogenesis from misplaced embryonic tissue; their individual pathology and clinical characteristics are exceedingly varied, but common to each other.

3. The terms multiple benign cystic epithelioma, lymphangioma tuberosum multiplex and adenoma sebaceum, or their numerous and varied synonyms, are not appropriate to the clinical and pathologic character of these affections. In view of their common pathogenesis and the close alliance of many of their clinical and pathological characteristics, these affections, to avoid any arbitrary reduplication and unnecessary redundancy in nomenclature, should be conveniently grouped into one class.

4. The pathology of each of these so-termed separate types of dermatologic affection embraces the hypertrophy of all the glandular elements and all the tissues of the skin in the most varied form and combination, and precludes the use of pathologic descriptive

terms in the nomenclature. In view of their common embryonic derivation, and the multiple discrete papular disseminated character of the lesions, an appropriate and generic nomenclature would be "Multiple Disseminated Embryonic Lichenoid Eruptions of the Skin."

5. Careful consideration should be given to the analogy which this class of affections bears to the clinical and pathologic changes of early malignancy, and to what extent malignancy owes its origin to lesions whose presence are due to the errors of embryonic development.

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DESCRIPTION OF PLATES.

- Fig. 1.—Multiple benign cystic epithelioma. A maternal aunt and uncle, two sons and two daughters similarly affected. The lesions developed in all the cases at the age of twenty-five to thirty years, and are distributed mostly on the nose. (Clinical type of the first class of cases).
- Fig. 2.—Multiple benign cystic epithelioma. Showing a number of glistening, translucent lesions, some centrally depressed. (Clinical type of the second class of cases.)
- Fig. 3.—Multiple benign cystic epithelioma, showing many short interlacing epithelial strands in the upper layer of the cutis, with a distribution for the most part parallel and vertical to the surface of the skin. The specimen also shows a cyst filled with colloid substance, several without contents, and a few remnants of sebaceous glands. This is the most common and striking form of pathological change in multiple benign cystic epithelioma, but is not constant enough to possess characteristic and pathognomonic value.
- Fig. 4.—Epithelial strands of Fig. 3, more strongly magnified, showing their parallel and vertical distribution, angular outline, bifurcating and stellate character. The strands consist of two or more rows of epithelial cells. At the bottom, the wall of an empty cyst can be readily seen.
- Fig. 5.—Chief pathologic change in the lesions obtained from the father in the first group of cases. Hair follicle in circumference and stratified contents, giving off peculiar-looking horn-like processes, single or branched in character.
- Fig. 6.—Showing characteristic cysts and adenoma of sebaceous glands.

EASY AND RAPID METHOD OF MICRO-CHEMICAL RE-
SEARCH FOR MERCURY IN THE URINE.

By Dr. C. LOMBARDO.

Read before the Sixth International Dermatological Congress, New York, September 9-14, 1907.

THE methods to ascertain the presence of mercury in the urine proposed by many authors are very numerous, but so far none of them has the character of practicality and rapidity sufficient to be employed in the laboratories of clinics, where delicate apparatus and special chemical knowledge are usually lacking.

These requirements, to my belief, are attained by the method which I am proposing.

It is based:

First—On the fact that the mercury is found in the urine of individuals subjected to mercurial treatment, as a compound not yet well defined, which reacts to the chloride of tin, which reduces it to metallic mercury even in minute quantities, and can be recognized under the microscope.

Second—That the reaction of chloride of tin on the solution of the mercurial salts, and of their compounds with the albumins, which can be perceived macroscopically in solutions at the utmost of 1x50,000, can be adding traces of albumin, and by using the centrifuge, be perceived in solutions much more diluted. By the microscope mercury globules can be seen one-half and one-quarter in one million, just as it is found in the urine.

The method is as follows:

In a tube of the centrifuge are poured five cubic centimeters of the urine to be examined, after having been filtered (preferably immediately after micturition); one drop of albumen of an egg is added and then agitated, to this is added three cubic centimeters of 12% solution of chloride of tin, filtered at the moment of using and hyperacidified with 25% of hydrochloric acid.

The urine at first shows turbidity, then becomes clear, finally opalescent from the tardy coagulation of the albumen; then the specimen is centrifuged for a few minutes. The fluid is removed and the precipitate at the bottom is taken with a pipette, and placed on a glass slide and covered with a coverglass, and examined under the microscope with a power of 600 diameters.

If the urine contains mercury, this is found in the precipitate in the form of extremely minute black globules of metallic mercury.

It is advisable to make the reaction of comparison with normal urine.

If larger quantities of urine are used, then on the obtained precipitate can be practiced the chemical reactions proper for mercury.

The method can be carried out in a few minutes and is just as sensitive as other methods much more complicated.

SOCIETY TRANSACTIONS.

CHICAGO DERMATOLOGICAL SOCIETY.

MEETING OF OCTOBER 25, 1907.

DR. FRANK H. MONTGOMERY, Chairman.

Two cases of **Leprosy** were shown by Dr. JAMES NEVINS HYDE. The first, B. F., a man twenty-nine years old, had been under observation since 1903, and was shown to the Society on February 25, 1903, as reported in the *JOURNAL OF CUTANEOUS DISEASES* for April, 1905. As supplementary to that report it may be said that he was born in Coddington, New South Wales, Australia; left that country in 1896 to become a sailor; was two and one-half years before the mast, during which time he visited Liverpool, London, Norway, Bergen, Gottenberg, Isle of Ceylon, Bombay, Penang, Singapore, Alexandria, Yokohama, Nangasaka, Hong Kong, Shanghai, Genoa, and the West Indies. At one time during his life as sailor he was associated for nine months with a man supposed to have leprosy. His contact with him was not especially intimate; they slept in the same cabin, but in different bunks, and occasionally clothing was interchanged between them. He came to America in 1900 and lived for two months in New Orleans. At the time of leaving Australia, a "patch" was present on the back, though he could not tell when it began. Leprosy is prevalent in the region from whence he came, there being an asylum for lepers at Coddington.

Some changes have taken place since the former demonstration. In 1904, new areas appeared upon the legs, arms, and shoulders; in November, 1906, the hands and feet were much swollen and quite painful; the pigmentation of the areas of trunk and limbs was becoming diffused; the face was more infiltrated and leonine in appearance. In August of the present year he suffered from an attack of dermatitis venenata. At present the infiltration in the face is marked, his color is a dark reddish-brown; the alteration in pigment of the body is diffuse; there is an ulcer upon the right ankle, which persistently refuses to heal.

The second case of Leprosy shown was in a man twenty-six years old, born in Russia, near the city of Riga. He came to this country ten years ago, has been married nine years, and has two healthy children. He was led to seek medical attention because of a dermatitis (supposed) of the face, which he stated had been present six months. Otherwise, he complained of no symptoms. His work is that of handling scrap iron.

The patient is of medium stature, rather spare, of relatively low intelligence, and appears much older than the age given. The face is heavy, leonine in appearance, with infiltration about the brows, ear, and

lips. The general color of the face is reddish-brown. Hands and fingers are swollen; the skin of the dorsi of hands is glossy and marked with bluish mottling. The arms, particularly the ulnar surface of the forearms and posterior surface of the arms, show numerous macules, reddish-brown in color, some of them slightly raised. The back shows many rather small areas of brownish pigmentation with numerous small white vitiliginous areas in the upper part; pigmented areas are present upon the legs; the skin over the right patella is considerably puffed; a large delicate scar is seen on upper part of the right calf posteriorly. There is but little change in sensibility; response to pain seems to be reduced over ulnar regions of the forearms. The roof of the mouth shows several raised areas and a scraping from one of these was found to be loaded with the characteristic bacilli. The nerve trunks in the neck and arms are palpable.

Case of Tuberculosis of the Skin (?). Presented by Dr. FISCHKIN.

Man, fifty-five years old, shows the following lesions. (a) On right cheek in the median line, about two inches above upper jaw an oval sore about one inch and a half by one inch in size, the basis of which clearly shows a tubercular character. The sore is of 8 years' duration. (b) On the lower lip at the edge of vermillion border a long, small plaque, made up of minute ulcers and of papillary excrescences which on the middle of the lip extended considerably downwards on the mucous membrane. The lesions existed since childhood and showed at times tendency to healing. (c) On chest about four inches from sternum and corresponding to the 6th and 8th ribs, two fistulous openings, covered with crusts. The patient's right apex is affected.

Case of Acne Necrotisans Serpiginosa Nasi. Presented by Dr. FISCHKIN.

Young man, twenty-six years old. On lower half of the nose aggregated pin to pea-sized papules, slightly elevated, reddish to brown-red in color, necrotic in the center. Between the papules as also on upper lip are scattered scars, of the same size. Patient complains of a severe burning sensation.

Case of Pityriasis Rosea. Presented by Dr. W. A. QUINN.

The lesions, in a woman of twenty-seven, were extensive, some of them atypical; considerable discussion followed as to the identity of the conditions, pityriasis rosea and herpes tonsurans maculosus.

Case of Cutaneous Blastomycosis. Presented by Dr. MONTGOMERY.

A man sixty-five years of age, a miller, in good general health. His disease began in January, 1907, as a pimple or small boil, on the cheek, and gradually spread over the nose and cheeks in the form of verrucous and ulcerating lesions. Soon after the disease began to spread on the face subcutaneous swellings appeared on the left forearm, which to-

gether with the left hand became greatly swollen and painful. After three months the swelling on the hand broke and discharged in several small openings. At the present time patient presents typical cutaneous lesions of blastomycosis of the nose and cheeks, and back of the hand. There is ectropion of the right lower lid. From the characteristic borders of the lesions blastomycetes were demonstrated in smears and recovered in cultures.

Case of Lupus Erythematosus. Presented by Dr. L. C. PARDEE.

The patient was a young woman of twenty years, in good general health, without significant family or past history. The present trouble began about four months ago as a small "red spot" on the left cheek, which gradually increased in size. At present it is about 4 c. m. in diameter, irregularly circular in shape, dark red in color, and covered with grayish, adherent scales; the edges are slightly raised. The case was of interest in the point of crescentic spreading and because at one stage the lesion suggested a late syphilide; at another a superficial type of blastomycosis.

Case of Multiple Sebaceous Cysts of the Scrotum. Presented by Dr. ORMSBY.

The patient, a man aged thirty-seven years, presented extensive involvement of almost the entire area of the scrotum, with pin-head to coffee-bean and larger sized, comparatively solid, tumor-like growths, which had existed since early childhood. At present the entire scrotal surface except on the posterior aspect is thickly studded with these masses. They vary in color from the normal color of the skin to a moderately yellowish shade. On puncture of some of these tumors, white, milk-like substance may be obtained; while from others only blood escapes. These lesions have, according to the patient's statement, gradually developed in number and size for many years, and there is no visible evidence of disappearance of any of them. There are no subjective sensations.

Case of Leucoplakia of the Vulva, with Carcinomatous Change. Presented by Dr. HYDE.

The patient, Mrs. H., was forty-eight years old, had been married thirty-two years, had given birth to six children. The vulvar alterations had been in progress several years. She states that the X-rays had been used for a period of five months, the last treatment having been given in October, 1906.

At present an indurated sclerotic mass involves the upper portion of the vulva, including the clitoris and upper portion of the labia, with a circular outline extending to the neighboring soft parts and with distinctly elevated border constituted of fused "pearls." There is distinct

leucoplakia of the internal faces of the labia majora and on the left side a circular fifty-cent-piece-sized elevated and vegetating lesion. On the opposite side are one or two smaller and less conspicuous but similar lesions. There is some inguinal adenopathy.

DR. ERNEST L. McEWEN, Reporter.

BOSTON DERMATOLOGICAL SOCIETY.

April Meeting.

DR. CHARLES J. WHITE in the Chair.

Adenoma Sebaceum, A Case of. Presented by Dr. HARVEY P. TOWLE.

This case, as is usual in adenoma sebaceum, occurred in a young woman and on the face. Ever since she could remember she had noticed the eruption; its spread having been extremely slow. Disseminated over the cheeks and about the mouth, with moderate profusion, were small papules, pin-head to somewhat larger in size, of a pale pinkish-yellow hue. On close inspection, some of those of redder appearance revealed fine telangiectases running over their surfaces.

DISCUSSION.

It was commented how closely this case agreed with adenoma sebaceum as usually illustrated and described.

Lupus Erythematosus(?). Presented by Dr. HARVEY P. TOWLE.

The patient, a woman twenty-three years old, has had this disease upon her nose for five years, and the few similar lesions upon the right cheek for about two years. The first manifestation was upon the right side of the nose. One by one the other lesions appeared until now there are from twenty to thirty scattered fairly evenly over the face from its base to the tip and on the sides. Except for the three or four near the mouth, none have appeared elsewhere. While one or two have attained a considerable size, in the majority the growth has been so slow as to be imperceptible. None have disappeared spontaneously, and they have given rise to no subjective symptoms. When first seen there seemed to be no question of the diagnosis of lupus erythematosus, but closer and longer observation has served to throw doubt upon its correctness. When first seen, Oct. 11, 1906, there were scattered over the nose many lesions of the average of the head of a large pin, and of a red-brown color, which nearly disappeared on pressure. The centers of some of the largest ones showed a whitish spot which suggested a beginning atrophy. A prominent feature was a very narrow bright red line which surrounded them. The largest lesion of all, situated on the right ala, was one of the first to appear and showed a central somewhat depressed, level, firm, almost cicatricial center. The patient was ordered *lotio alba*. On her return, two weeks later, several of the larger lesions were covered with crusts, arranged in layers and somewhat depressed centrally. The

majority presented firm rounded masses, which projected slightly above the surface and which seemed to arise from the mouths of the ducts. The crusting quickly disappeared and the lesions seemed to grow harder and firmer. Now, if the finger is passed over the surface of the nose, the projecting masses give a distinct grating sensation. None of the lesions have visibly increased in size and none have disappeared. An attempt to incise the center of the largest lesion met with such resistance that considerable force was necessary. The projections showed the same hardness. The surrounding red zone has persisted and is still prominent. It has been noticed that the intensity of the color of the lesions is not always the same. Heat seems to increase the color and cold diminish it. With the increase of color from heating seems to go a quite marked perspiration of the nose, although the skin elsewhere shows nothing.

DISCUSSION.

This case was considered to be lupus erythematosus by a majority of those present. On account of certain peculiarities, Dr. Towle was inclined to distinguish it by the name lupus erythematoïdes (Leloir); a supposed mixed type of lupus vulgaris and lupus erythematosus.

Extragenital Chancre. Presented by Dr. HARVEY P. TOWLE.

This case is interesting only in connection with the similar cases of primary lesions of the lips which have been shown at previous meetings. The patient, a man of fifty-four, came to the Out-patient Department of the Massachusetts General Hospital with a sore on his lips which he said had been there for two weeks. One week later, when seen in consultation with Dr. Burns, it was thought that a roseola was developing upon the flanks and upon the inner surfaces of the forearms. To-night it can be plainly seen.

Dermatitis Callorica or Hydroa-aestivale? A Case of. Presented by Dr. CHARLES J. WHITE.

The patient was a boy who, for the last two winters, had suffered from a perpetual dermatitis of the exposed portions of both ears. The boy was subjected to frequent refrigeration through his occupation of driving a wagon. The lesions consisted of circumscribed areas of dark red infiltration and oedema, and according to the lad's story they had been perpetually present throughout the cold months of the previous winter, and were still evident, although the severe cold was now past.

DISCUSSION.

The peculiarities shown by the ears in this case were thought to be rather the result of frostbite and continued subjection to cold than a process due to any inherent deficiency of the tissues as hydro æstivale or Raynaud's disease.

Pityriasis Rosea of Atypical Distribution. Presented by Dr. F. S. BURNS.

A man, thirty-nine years of age, usually in good health, developed a skin eruption two weeks ago mainly affecting the sides of the neck, but

also showing a few less well defined lesions on the flexor surfaces of the arms and on the anterior aspects of the thighs. Mild pruritus is the only subjective discomfort the patient has felt. The first of the eruption seen was a quarter-sized area directly under the mental process of the inferior maxilla. Thence the eruption spread down over the sides and front of the neck, covering, in the course of five to six days, a major portion of that region. From time to time, subsequently, the lesions on the arms and legs have appeared, though on these regions the individual lesions have never been so pronounced as those on the neck. The eruption is macular, annular, and circinate. Most of the ringed lesions on the neck are of oval contour with rosaceous and slightly palpable borders, and possess centers of a light café-au-lait hue, covered with fine furfuraceous scales. After viewing the neck it can be readily seen that the lesions on the limbs partake of similar characteristics, though less pronounced.

DISCUSSION.

Opinion generally concurred that this was a case of pityriasis rosea. The unusual locations of the outbreak was considered noteworthy.

F. S. BURNS, Secretary.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON DERMATOLOGY.

Stated Meeting, held October 1, 1907.

DR. A. R. ROBINSON in the Chair.

A Case for Diagnosis. Presented by DR. ORLEMAN ROBINSON.

Girl, age twenty-two months. She had whooping-cough at the age of eighteen months. There are three other children in the family, all healthy and free of any cutaneous diseases. There is no history of rheumatism or tuberculosis in the family. The lesions were first observed in June, the first one forming on the dorsum of the right foot; subsequently others formed on the legs, especially below the knees.

Status praesens: The lesions on the leg vary in size from a pea to nearly one inch in diameter. The most recent lesion situated on the anterior surface of the leg is pea-sized, sharply limited, slightly elevated, moderately rounded surface, reddish in color, the redness disappearing considerably upon pressure, and is somewhat scaly, the scales being composed of epithelial cells as shown by a microscopical examination. Upon the removal of some of the scales by a blunt instrument there was a rapid formation of an urticarial-like lesion with some itching. The other lesions on the leg vary from this one only in size, with the exception of one which is situated over the crest of the tibia and is one inch in diameter. It is fairly circular in form, sharply limited, elevated about one-eighth of an inch above the general surface, flattened, pale red in

color, with a shining non-scale surface. It is firm to the touch and appears as a slightly movable mass in the corium. This lesion formed one month ago, commencing like the pea-sized lesion previously described.

The largest lesion situated just below the ankle is one inch in diameter, roundish in shape, sharply limited, and elevated, the elevation starting abruptly from the general surface. The whole lesion presents a flattened surface. The peripheral portion, to the extent of one-sixth of an inch, is slightly more elevated than the rest of the lesion. The central part is dark red in color. The elevated periphery is whitish in appearance and is surrounded by a very small red areola, the redness disappearing very much upon pressure and reappearing quickly after removal of the pressure. The lesion is firm, giving the sensation of a sharply-limited new formation in the cutis. The surface presents a slightly scaly appearance.

Subjective symptoms are absent in all the lesions. Vasomotor disturbance on any part of the general cutaneous surface was easily produced by traumatism, red lines forming quickly, produced by injury from a blunt instrument, but the manner of reaction was insufficient to term the lesion one of *urticaria factitia*. The case has been one week under my observation, during which time the lesions have not altered in appearance.

The case is shown on account of the peculiar character of some of the lesions, the long duration of the lesions and the inability to place it among any of the well-recognized forms of erythema or other cutaneous diseases. It is evidently not a case of chronic urticaria, either symptomatic or idiopathic, nor of erythema induratum. I feel that only a microscopical examination will clear up the diagnosis.

Case of Elephantiasis. Presented by Dr. HOWARD FOX.

Miss ———, thirty-one, born in United States, where she has always lived, school teacher. An aunt is said to have suffered from a "milk leg." There is no other relative who has suffered from any enlargement of the extremities. Twelve years ago the patient first noticed a swelling of the right leg just above the shoe tops. From that time to the present the leg has steadily increased in size. Within three years the enlargement had extended up to the knee. She has had three attacks of phlebitis at intervals of two years, which confine her to bed for a fortnight. Treatment by electricity for six months has produced no improvement. Two months ago she began to suffer from a pruritic and oozing eruption of right leg and inner aspect of thigh. With the exception of this eruption, for which she seeks relief, she has suffered very little inconvenience from her affliction. The right leg measures 23 inches at the calf and 33 inches at the thigh, while the left leg (normal in appearance) measures $14\frac{1}{2}$ inches at the calf and $21\frac{1}{2}$ at the thigh. The enlargement of the right leg has extended slightly above Ponpart's ligament. The genitalia are not affected. She weighs 200 pounds, but has

the appearance of a woman weighing about 150 pounds. Previous to the eruption the skin had always been fairly normal in appearance. She limps slightly in walking. Her general health is excellent.

Sclerosis of Each Nipple. Presented for Dr. GOTTHEIL.

Mary M., age twenty-six, admitted to City Hospital Sept. 21, 1907, with the following history:

Six weeks ago her husband bit her on each nipple; did not cause any bleeding at the time, but left marks of his teeth. She took no notice of these marks at that time. As they gradually got worse, which fact the patient attributes to the irritation of her cloths, she came to the hospital for relief.

EXAMINATION.

Right Breast—Just above and outside the areola is an oval inflamed elevated and eroded mass, about $\frac{1}{2} \times \frac{3}{4}$ inch in size, borders brownish-red and angry looking; center, depressed and exulcerated; the whole lesion marked by the painless, typical sclerosis of its base.

Left Breast—Entire nipple and areolar area swollen, reddened and covered with a brownish adherent crust; the nipple is enlarged to four times its normal size. The affected area shows a number of superficial circinate erosions. Around the entire nipple and areolar area is the hard, typical, painless, and sharply circumscribed indurated condition so characteristic of an initial sclerosis. The skin of this breast is intensely reddened and studded with a close set papulo-vesicular eruption. This condition is regarded as due to some external irritant, though the patient denies having used anything but vaseline. There is a general macular eruption, with distinct lesions on the left palm. Typical angina, and adenopathy.

Sept. 30—The large brown, red crust, covering the left breast, has come away, exposing a half-dollar size eroded lesion. The eczematous condition of the right breast is disappearing. The eroded mass on this breast has become slightly more elevated, otherwise unchanged.

There is a general small papular syphiloderm now present.

A Case of Syphilis. Presented by Dr. DAISY ORLEMAN ROBINSON.

J. L., female, age twenty-five, married. She came to my clinic at the North Western Dispensary, May 13, 1907. Examination showed a sore located on the right labium majus, which was oblong in shape, about one and one-fourth inches in length, and five-eighths of an inch in width at its widest part. It was sharply limited, elevated, and of firm margin. The surface was eroded, having a very slight secretion, reddish in color, with the central part depressed. The whole ulcer had a hardened feeling, and microscopically resembled an epithelioma on account of the reddish base, slight secretion, firm, sharply limited, deeply infiltrated margin, and larger size. No enlargement of the inguinal glands was observed.

Patient passed from my observation until September eighteenth. She states that an eruption appeared on the body in the early part of July, accompanied by pains in the joints and considerable fever. A mercurial preparation was prescribed by a physician in August. When I saw her again, she had a general syphilide, the lesions ranging from small papules to large tubercles, and large areas of general infiltration. The majority of the lesions were on the face, neck, forearms, and hands. The small papules were located specially upon the neck and elbow region, and showed a tendency to grouping. The papules and tubercles varied in size from a pea to a bean and even larger. There were patches of infiltrated areas especially upon the wrists. The anterior surfaces of the wrists were occupied by some papules, tubercles, and large infiltrated patches, the latter occupying the entire anterior surfaces of the wrists extending to the base of the thumb. The patch was an elevated, sharply limited, scaly, infiltrated one, as observed in chronic psoriasis or chronic dry scaly eczema. There was a well-marked leukoderma syphilitica on the sides and back of the neck and the upper parts of the shoulders. I had not observed that the whitish spots occupied the seat of previous lesions. The lesions upon the legs and body were large flattened lesions varying in size from a bean to a finger nail.

The case is shown on account of the unusually large size of the primary sore with its marked resemblance to an epithelioma, the multi-form character of the secondary lesions and the leucoderma syphilitica.

Case of Hereditary Syphilis. Presented by Dr. HOWARD FOX.

Patient is thirty-one years old, single, French-Canadian, seamstress. Her mother is living and healthy. When her father was twenty-seven years old he confessed to having contracted a "bad sickness." Previous to this, one daughter was born, who is now living and healthy, and one son, who died of small pox. Four children were born subsequent to the father's illness. The first child, a boy, born four months later, died four years ago of consumption. The other three children, all girls, were born two years and eight months, seven years, and twelve years, respectively, after the father's illness. The first is our patient. The second has always been delicate. She had a son who suffered from "asthma" shortly after birth and died of meningitis in his third year. The third died at four years of age of "brain fever."

The patient was apparently healthy at birth and remained so up to her eighth year. She then suffered from "lumps" in her nose and was treated for catarrh, but without benefit. A little later the nose began to ulcerate and within a year had entirely disappeared. At the same time there were deep sores on the cheeks. At fourteen she was treated at Randall's Island and after sixteen months all the sores had disappeared. Since then her appearance has remained practically unchanged. Examination shows the patient to be thin and delicate. The entire nose

and in addition the entire septum, middle and lower turbinate bones are absent. The hard palate and superior turbinates are intact. The upper lip has disappeared and the lower lip is drawn down by cicatricial contractions, disclosing two frightful-looking rows of teeth. Some of the latter are loose and their roots are exposed by retraction of the gums. The checks show extensive scarring.

Sarcoma Cutis Haemorrhagica. Presented by Dr. WILLIAMS.

The patient is a Jew, fifty-six years of age. He first applied to Dr. Bulkley's service at the Skin and Cancer Hospital, October 15, 1905. He said the disease had then been in existence for three years. He then showed disseminated brownish and pulplish indurated masses on the hands and feet. The right instep was swollen, and both feet were very painful on slight pressure, while the hands were not painful. He was given X-ray exposures every second day, twenty minutes each to hands and feet, and internally, half an ounce of neurotone three times a day. The hands improved rapidly, the feet more slowly. X-ray ulcers developed, and were very slow to heal, that on the hand lasting until August, 1906, and that on the foot a few months longer. There has been no X-ray treatment since May, 1906, but the internal administration of arsenic has been continued for the past year in doses of Arsenious Acid gr. 1-50, three times a day. He now shows scars at the sites of the old X-ray burns, but the disease here seems to be arrested. There are new lesions, however, on the forearms—firm masses, deep in the skin, brownish and purplish in color, and not ulcerated.

• **THE PHILADELPHIA DERMATOLOGICAL SOCIETY.**

The regular monthly meeting of the Philadelphia Dermatological Society was held at the Jefferson Hospital on Tuesday evening, November 19, 1907, at 8:30 o'clock, with Dr. M. B. Hartzell in the chair.

Ulcerating Vascular Naevus, An Extensive Case of. Exhibited by Dr. HARTZELL.

The patient was a baby nine months of age. The growth of this naevus had been progressive since birth. This hypertrophy of the vascular tissues extended from the axilla and the upper part of the right shoulder, all the way down the arm, forearm, and included the palmar and dorsal surfaces of the right hand, and the fingers. At birth this condition occupied about one-half of the area now involved. Sensation was normal or possibly hyper-acute. There was a tendency to hæmatoma formation, particularly in the axilla. The sound skin between these blood vessels was of a bluish tinge. Motion of the arm was slightly impaired. The baby was in perfect health, plump and with a good color, she slept well, and was not particularly irritable. The remarkable thing in this case was

the fact that six months ago ulceration, apparently spontaneous, commenced in this nævus. This ulceration has been progressive, until now the entire outer surface of the nævus, reaching from the shoulder to the elbow, is involved in the one large ulcer. The ulcerated area is composed of many small ulcers, which have become confluent; destroying one-third of the upper arm. The pain is apparently slight, as the baby sleeps well, and does not cry excepting when the ulcerating surface is exposed to the air.

Transitory Benign Plaques of the Tongue, A Probable Case of. Shown by Dr. GASKILL.

The patient was a woman of fifty years, and had suffered from this condition for nine months. Three-quarters of the dorsal surface of the tongue was covered by two large, somewhat irregularly-shaped plaques; whitish in color, and resembling, excepting for their formation, a furred tongue. A few flat, slightly raised plaques, large pin-head in size, were noted on the right edge of the tongue, suggesting very strongly syphilis. Burning was complained of at night and on taking sour drinks. Several important points were brought out in the discussion; that glossitis sometimes results from the trophic changes from drilling and filling the teeth; that electric currents are sometimes set up by various fillings, thereby causing trophic changes. Gastro-intestinal disorders and syphilis were suggested as causal in this case.

Hypertrophic Lichen Planus, A Probable Case of. Presented by Dr. STELWAGON.

The patient was a woman twenty-five years of age and had suffered with this eruption, according to her statement, almost continuously for twenty years. The lesions were limited to the lower legs and consisted of about fifty deep-seated, split-pea sized and larger nodules, with a slightly scaly, rough, violaceous surface. Crops of vesicular lesions had been noted in the same location. There was intense pruritus. This patient had been shown at a previous meeting with lesions of the same character. Almost every form of treatment had been tried, including the X-rays; a strong chrysarobin ointment being the most beneficial. The members agreed that the classification was extremely difficult, several suggesting the resemblance to the cases of multiple itching tumors of the skin, reported by Hardaway, and by Schamberg.

A Case for Diagnosis. Presented by Dr. DAVIS.

The patient was a female of thirty-eight years. This condition had first been noted nine months previously. On the left side of the back, just below the margin of the ribs, there was seen a silver-dollar-sized reticulated patch, with pinkish-red lines, one-eighth of an inch in thickness, radiating across the surface. This patch was non-elevated, smooth, and showed no infiltration. At the first glance the resemblance to a syphilitic scar was marked, but on closer inspection the white areas were found to

be sound skin and not scar tissue. The pink color in the lesion could not be pressed out. Several possibilities as to diagnosis were suggested, but no conclusions were reached.

Dermatitis Repens, A Probable Case of. Exhibited by Dr. DAVIS.

The patient was a woman twenty-eight years of age, and she had first noted this condition eight months ago. The disease first started on the dorsal surface of the right hand, as a few small vesicles. These vesicles increased in size, broke, and then showed a raw, oozing surface. The epidermis surrounding the edges became more and more undermined, until the various patches became confluent. At the present time the entire dorsal surface of the right hand is involved, by this progressive, undermining dermatitis, from the wrist to, and including several of the fingers. The patient also has a few patches of seborrhoic eczema on the forearms.

Cutaneous Atrophy, A Case of. Exhibited by Dr. SCHAMBERG.

The patient was a girl of twenty years, and had first noticed this condition fifteen months previously. The entire face, the neck, the upper part of the back, and the shoulders were covered with pin point to small pin-head sized scars, really minute, non-infiltrated depressions. The skin was pliant and smooth. On the shoulders minute telangiectases were also noted. There was no scaliness or subjective symptoms. The face was somewhat congested, in the shape of a bat's wing, but this apparently was not pathological. The two diagnoses considered in this case were morphœa and lupus erythematosus. No cause for the cutaneous atrophy was discovered.

Epithelioma, An Extensive Case of. Presented by Dr. SCHAMBERG.

The patient was a male of thirty-six years. The growth had started some years previously, and had been operated on three times during the last five years; each time with a recurrence. The patient had received numerous treatments with the X-rays, with resulting marked improvement. At the present time there is a quarter-dollar sized, deeply ulcerated lesion just to the right of the right eye, surrounded by a cicatrizing surface, where the former ulceration had healed. The case was shown with the thought that the present ulceration might have resulted from the X-ray treatment. The majority of those present agreed that some epitheliomatous tissue still remained.

Eczema Seborrhoicum, Resembling Lupus Erythematosus, A Case of.

Shown by Dr. DAVIS.

The patient, a male of thirty-seven, stated that the condition had lasted for some years. On the cheeks and the nose there was an erythematosus, slightly scaly eruption, which bore a resemblance to the butterfly arrangement of erythematosus lupus. The ducts of some of the sebaceous glands seemed to be somewhat patulous. The condition had improved markedly under mild treatment.

FRANK CROZER KNOWLES, M. D., Reporter.

REVIEW
of
DERMATOLOGY AND SYPHILIS

Under the charge of A. D. MEWBORN, M. D.

BACTERIOLOGY AND PARASITOLOGY.

By A. D. MEWBORN, M. D.

Dermatitis of Ground Itch, The Causative Factor in the Production of the. C. A. SMITH. *Journal A. M. A.*, 1906, p. 1693.

In an attempt to prove that the larvæ of the *Uncinaria Americana* secrete an irritating substance in their passage through the skin in ground itch, the author collected a number of larvæ in the following manner: Sterile earth and water were mixed with human feces containing eggs of the uncinaria and placed in deep specimen jars. These jars were covered and placed in a cool draft of air to precipitate moisture on the inner sides of the jars. When the larvæ were hatched out in four days they climbed up on the insides of the jars aided by the moisture. The larvæ could then be easily collected on cotton swabs dried and put in absolute alcohol to extract the toxic substance. This alcohol containing the toxic principle was put on absorbent cotton and applied to the wrists of the subject of experimentation. In 24 hours there developed an eruption with severe itching. On the third day the eruption became vesicular and the irritation attained its height in four days, gradually subsiding on the 8th day. His experiments seem to prove that the eruption and itching are caused by the secretion of an irritating substance of the nature of toxicodendrol. The scratching and rubbing induced, favor the migration of the larvæ through the skin.

Dermatomycosis of the Non-hairy Regions in Man Caused by the Microsporion Canis. J. NICOLAS and U. LACOMME. *Ann. d. Derm. e. Syph.* 1906, p. 321.

The lesions in the patient here described as well as those in the dog from which the disease was contracted, appear to be absolutely identical with those described by the reviewer in a case contracted from a cat (*New York Medical Journal*, November 15, 1902).

Cultures upon glucose agar and beer wort agar taken from the patient and from the suspected dog gave practically identical growths.

These growths have the same characteristic concentric circles with yellow centers. Microscopically the cultures showed numerous fusiform

44 REVIEW OF DERMATOLOGY AND SYPHILIS.

chlamydospores with numerous partitions. Inoculation experiments produced typical small spored patches of ringworm.

Microsporons, Recent Research Concerning the. (*Nouvelles Recherches sur les Microsporums*, by R. SABOURAUD, *Annales d. Derm. e Syph.*, 1907, March, pp. 160 to 183; April, pp. 225 to 245; May, pp. 326 to 336; June, pp. 369 to 386.)

After the exhaustive researches of Sabouraud upon the parasitic fungi of the scalp made twelve years ago, it is not surprising that he has found so many points of interest in the four studies here presented. The first point emphasized is that the expensive anhydrose glucoses, lactoses, maltoses, etc., are not as good for differentiating cultures as the commercial maltose, or glucose, which costs four francs a kilogram instead of two hundred, and when one considers the enormous quantity required in the course of a year for laboratory work this saving alone amounts to several hundred dollars. The two formulæ used in these studies were as follows:

Aqua,	1000.
Maltose brut de Chanut,	40.
Peptone granulée de Chassaing,	10.
Agar-Agar,	18.

and

Aqua,	1000.
Glucose massée de Chanut,	40.
Peptone granulée de Chassaing,	10.
Agar-Agar,	18.

It is only by means of comparing results upon the same medium that anything like international comparison of cultures can be thought of, these formulæ are, therefore, the most approved "milieux d'épreuve."

With cultures obtained by using the first formula Sabouraud gives superb double photographs of seven varieties of the microsporon:

1. Microsporon Audouini (Sabouraud).
2. Microsporon lanosum (Sabouraud).
3. Microsporon felinum (Colcott, Fox and Blaxall).
4. Microsporon umbonatum (Sabouraud).
5. Microsporon equinum (Bodin).
6. Microsporon caninum (Bodin and Almy).
7. Microsporon velveticum (Sabouraud).

Each variety presents a distinct typical picture in flask cultures. All of these varieties have been described elsewhere except the Microsporon lanosum, a new variety, which at the present time is the cause of one-third of the cases of small-spored ringworm met with at Paris. For description of cultures the reader is referred to the original. Clinically, this form of microsporon is characterized by the number and small size of patches, by the accompanying inflammatory reaction, often by an

accompanying generalized herpes of circinate type, and by the fact that it may affect the beard in man and cause a disseminated folliculitis. Its rapid growth in cultures and ease with which it may be inoculated upon guinea-pigs stamps it as probably of animal origin, although quite distinct from other animal forms already described.

It is a curious fact that in 1892 there were twice as many cases of microsporon infections as of trichophyton, but at present, owing to the rapid cure of the more easily recognizable types by the X-ray treatment, the percentage is reversed, *i. e.*, there are now twice as many trichophyton as microsporon cases.

In the extemporaneous examination of the suspected hair Sabouraud employs the 30% caustic potash solution or clears in formol (40%?). Staining process followed is to remove fat by chloroform, place in watch glass containing formol and heat for two or three minutes until ebullition, wash in distilled water, stain for a minute in Sahli blue, wash, dehydrate, xylol, balsam.

From a study of the morphology of the microsporon lanosum in its ectothrix and endothrix invasion (second and third article), Sabouraud shows that this fungus invades the horny layer of the epidermis by a plexus of sinuous filaments. The mouth of the hair follicle is invaded by agglomerated giant mycelium, forming a mycosic cone. The epidermis of the follicle around the hair is next invaded by a fine network of slender mycelium. Then giant ribbon-like mycelium descends from the mycosic cone, lying upon the hair shaft, bifurcating downward, breaks up into little islands of faceted large spores. The subdivision of these spores into smaller elements constitutes the sheath of small spores which is carried upward by the growth of the hair.

The third paper describes other mycelial filaments arising from the giant filaments and insinuating themselves into the trunk of hair shaft about the middle of its radicular portion these endothrix filaments become more and more delicate as well as numerous, some terminate in sigmoid branches on the surface of the hair shaft underneath the layer of small spores, other filaments in the hair shaft extend even below the enveloping sheath of spores as a filamentous fringe. "fringe of Adamson."

The fourth paper goes into the morphology of the endothrix filaments and the different theories as to the small-spore formation. The author acknowledges that there are still a number of obscure points to be elucidated.

TREATMENT OF VASCULAR NAEVI BY RADIUM.

A communication to the Academy of Medicine of Paris, October 8, 1907, by Dr. Louis Wickham and Dr. Degrais.

[This contribution emanates from the Laboratoire Biologique de Radium of Paris of which Dr. Wickham is the clinical chief.]

In previous papers Wickham has stated that radium has a beneficial therapeutic action on epitheliomata, certain rebellious forms of eczema, prurigo, névrodermites and psoriasis.

The possibility of employing radium for the removal of vascular naevi was impressed upon the minds of the present authors by their previous demonstrations of the obliterative action of the metal on the capillaries and at the last meeting of the Paris Academy, they presented numerous tinted photographs illustrating the successful issue of their experiments on some vascular naevi varying from small angiomas to extensive, elevated erectile tumors.

The method of procedure consists in incorporating salts of radium of varying strengths in varnish and applying this paint directly to the surface of the vascular growth. To determine the duration of the application one must know the power of the salt employed and the structure of the lesion to be treated. For instance, 20 cm. of a salt (whose activity is 500,000 and which gives off 5% of alpha rays, 85% of beta rays and 10% of gamma rays) will produce an exulceration in one application lasting a half hour.

Wickham and Degrais have found that for flat and superficial naevi a light exulcerative action is necessary; while upon deeper tumors one must act more vigorously; and on those which project above the surface mild and repeated applications must be made which do not exert any visible, appreciable action at the time.

Two striking characteristics have been recorded in these experiments, i. e., the power of repair of the tissues and the absolute painlessness of the treatment. Regarding the former fact histological and clinical observations have demonstrated the embryonic rather than the customary inflammatory reaction of repair resulting in a tissue which hardly merits the name cicatrix; as to the latter characteristic one must be impressed with its great value when dealing with pathological conditions which affect principally infants and children, for a slight burning sensation seems to be the sole subjective symptom.

BOOK REVIEWS.

A Handbook of Skin Diseases and Their Treatment. By ARTHUR WHITFIELD, M. D. (London), F. R. C. P. New York and London, 1907. 320 pages. Illustrated.

This little book contains between its covers good things quite out of proportion to its size. Though the author says in his preface that the book was written for students, it seems to us that the physician who has had some experience in dermatology will be more profited by it than the student. There is a good deal of controversial matter in it that is interesting and suggestive, but that is not what the student craves. Moreover he wants clear-cut descriptions of the clinical features of disease, and it seems to us that it would be difficult for him to form an adequate idea of not a few of the diseases of the skin as portrayed in this book. On the other hand the author has given here the fruit of his experience as a dermatologist, the result being a book valuable far and away beyond that of the ordinary "Handbook."

With a few words about the anatomy and physiology of the skin, its lesions and general therapeutics, the author takes up the discussion of the dermatoses, beginning with those due to pyogenic infection. Without any definite classification, an attempt has been made to group diseases either under their etiology or symptomatology, such as those due to pyogenic infection, parasites, itching, erythema, seborrhœa, and the like. In an appendix useful directions are given for the preparation of specimens for microscopical examination.

It is a surprise to find dermatitis exfoliativa neonatorum placed under contagious impetigo, and pompholyx, improperly called cheiropompholyx, regarded as only an acute eczema of the hands. The opsonic method of treatment is given and endorsed; and the indications and technique of Radiotherapy are well presented. Lactate of calcium is commended in urticaria and erythema nodosum. The latter, by the way, is held to be a disease distinct from erythema multiforme. Only the oily form of seborrhœa is recognized. In the etiology of eczema are given heredity, asthma, gout, and nervous conditions. In so common a disease as eczema it would be hard to prove that heredity is an etiological factor; and as to asthma, while there is no doubt that it and eczema sometimes play hide and seek, it would seem more rational to believe that both are due to the same underlying cause in a given case. It would be quite as rational to say that asthma was due to eczema as the reverse. Jacquet insists upon carious teeth as a cause of some cases of alopecia areata. This is partially accepted by our author, who adds eye-strain to the possible causes of the disease, as well as severe infection with pediculi capitis. These citations from the book will serve to show how suggestive it is.

We regret that we can not say a word in commendation of the illustrations. Our cousins across the sea can take beautiful photographs, but they do not seem to have mastered the art of halftone illustrations.

G. T. J.

Text Book of Diseases of the Skin. By ARTHUR VAN HARLINGEN, Ph.B. (Yale), M. D. 4th Edition. Thoroughly revised and rearranged with 102 illustrations. Phila. P. Blakiston's Son & Co. 1907. Pages 482. Price \$3.00 net.

Usually when a book has reached a fourth edition, the reviewer's task is easy. He has but to say: "Well done. Receive my congratulations, and best wishes for many reincarnations"; and his task is done.

It is not so in the case of the book now before us. Our old friend, the book, not the author, twelve years after the appearance of the third edition, has burst out into new life in a new dress. In previous editions the diseases were arranged in alphabetical order; in this they appear in the usual sequence, following the classification of Hebra. The former edition has suffered the fashionable operation of appendectomy—its appendix on diet in diseases of the skin has been cut off. I doubt if its health has been improved by the operation. The number of illustrations has been increased from 60 to 102, many of the new ones being excellent. Most wonderful of all, it has decreased in size, in spite of the immense amount of new knowledge that has been acquired during the years since last it was welcomed by the medical public.

Like in the previous editions, so in this, the subject matter is conservative, and the treatment advised is along the old well-tried lines. For a "Text Book" many of the diseases are inadequately described. The best section of treatment is that on eczema, which spreads over 45 pages, while to that of syphilis only one page is devoted, and in it no mention is made of intramuscular injections of mercury. The indications for the use of X-rays are quite fully given. That they are not mentioned in connection with the treatment of ringworm of the scalp is doubtless an oversight on the part of the author. We fail to find any mention of opsonins, and of the newer methods of light therapy, excepting that of the Finsen light.

The differential diagnosis of the principal skin diseases, is well detailed. This is but one of the commendable features of the book that have won for it an honorable place in the literature of dermatology, and called for so many editions.

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Tobacco.

Other disease causes.

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Injection treatment.

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Poisoning by mercury.

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